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SOCIAL WORK



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CLASSIFICATION AND DISTRIBUTION OF

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II

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## CHAPTER I

### INTRODUCTION

Those of us who are social workers and students of social work are frequently asked by the professional people and layman about social work in the military setting. The purpose of this thesis is to attempt to evaluate on what basis social work was possible in the Neuropsychiatric Section of Camp Edwards Convalescent Hospital.

The questions we will presume to answer are those growing out of this experience. What kind of social work is possible? How much treatment is possible? What are the elements in the army situation affecting practice? Can group therapy be used as an aid to individual therapy? How much help can a patient be given in a few short interviews? What is the value of group therapy? Can resources such as physical training and occupational therapy be utilized in the case work plan?

This study describes the Neuropsychiatric Treatment Section of the First Service Command Convalescent Hospital, Camp Edwards, Massachusetts, from January 1945 until January 1946 with emphasis on psychiatric social work.

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gram (including physical and occupational therapy classes and all seasonable sports) during the day as well as many leisure time activities during the evening. Although in form this was done in a military setting, there was only a small amount of what could be called "G.I."

During a large part of the period under discussion "all open ward N.P. patients" were handled by the Neuropsychiatric section of the Convalescent Hospital. As the general hospitals were crowded because of the vast increase in casualties from overseas, the number of cases increased rapidly from about five hundred in February to over three thousand in July, 1945. From this peak and largely due to the above conditions being reversed, the number of cases declined even more rapidly until the Convalescent Hospital went out of existence as a separate entity in February 1946.

The size of the professional staff increased from three psychiatrists, two officer psychologists, eight psychiatric social workers and one WAC psychometrist in February 1945 to a peak of approximately fifteen psychiatrists, twelve clinical psychologists, forty psychiatric social workers, four WAC psychometrists and four civilian psychometrists in July 1945 with administrative cadre in proportion. Our personnel increased and declined at roughly the same times as the case load, but not in corresponding proportions. As a consequence at many crucial times in our history, we are critically understaffed.

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The size of the professional staff increased from three psychiatrists, two officer psychologists, eight psychiatric social workers and one WAC psychometrist in February 1945 to a peak of approximately fifteen psychiatrists, twelve clinical psychologists, forty psychiatric social workers, four WAC psychometrists and four civilian psychometrists in July 1945 with administrative cadre in proportion. Our personnel increased and declined at roughly the same times as the case load, but not in corresponding proportions. As a consequence at many crucial times in our history, we are critically understaffed.

tors involved in the problem and procedure of treatment in all these cases which were as follows:

1. Each case was discussed with the case work supervisor, who usually had also seen the patient, as to the type of treatment advisable and the results were carried out as far as possible.
2. The fact that the overseas records were often incomplete or inaccurate in the light of the current situation made it necessary to use them critically.
3. The structure and function of the Neuropsychiatric Section of Convalescent Hospital often seemed confused and necessitated even more than in the average civilian case work agency a constructive appreciation and use of function and limitation. This meant also that attention was focused almost entirely on the present problem.
4. There was, except in the case of the psychopaths, a quick establishment of rapport and yet not an identification with the patient's gripes.
5. Blood tests and x-rays were given to all patients and other tests performed where indicated. Therefore, unless otherwise indicated, it can be considered that no physical basis was found for the patient's complaints.

Throughout the treatment cases various terms was used as they occurred in practice. Since there are relatively close working relationship between psychiatrists, psychologists and psychiatric social worker, the methods of

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The sources of data in this study can be grouped under the following two main headings in order of emphasis:

1. Case material of the writer from January 1945 to January 1946.
2. Studies and reports by the staff of the Neuropsychiatric Section of the First Service Command Convalescent Hospital.

The method of procedure was by specific and general case analysis as well as presentation of data on observation during group therapy, reactions in general and to other parts of the program. The treatment cases were analyzed to better understand techniques used in treatment as well as responses and reactions to treatment and to the environment. Typical cases were selected as representative of a cross section of both the case load, process and treatment and they represent failure as well as success.

It is the feeling of the writer (in common with others) that the treatment of Neuropsychiatric patients in the First Service Command Convalescent Hospital furnishes a valid psychiatric social work experience and should be recorded. There is value in this as a concrete demonstration of what can be done under definite limitations thru an appreciation of and a constructive use of function. In addition the case material and observations may be of value for people dealing with the "psychoneurotic" veteran in furnishing information that will give a greater ability to understand and appreciate the na-

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ture of his experience as well as perhaps in other phases of civilian practice.

Not unlike civilian agencies, psychiatric treatment centers in the army suffered from limitations. In common with its civilian counterparts during this period, there was a shortage of adequately trained personnel and lack of an adequate in-service-training program. This not only made treatment and psychiatric consultation difficult, but in addition reduced the value of overseas records which at best were usually incomplete. In addition the type and number of clients were determined not by the agency but by the War Department policy. In fact, because of the pressure of the number of casualties, the Neuro-psychiatric section was handling all types of cases including psychopaths. This created problems in morale and administration. It is also obvious that there was little selectivity by the individual convalescent hospital and almost no client determination. Besides the problem of evaluation of the accuracy of the overseas record, we had to depend, except in a very few cases, upon a social history secured from the client himself.<sup>1/</sup> Another limitation is the fact that all the cases discussed, except as specifically mentioned, are those selected from the experience of the writer.

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## CHAPTER II

### THE NEUROPSYCHIATRIC SECTION OF THE FIRST SERVICE COMMAND AND CONVALESCENT HOSPITAL

#### History

In July 1944 a reconditioning program was set up for neuropsychiatric patients of the First Service Command at Fort Devens, Mass. The purpose stated by the War Department was as follows:

#### 1. Introduction.

- a. Section IV. A.S.F. Circular No.175,1944 directs that any patient who has even a remote chance for salvage for additional military training will be given a trial in reconditioning, and that the reconditioning program will be extended to include the majority of neuropsychiatric patients. It provides for the inclusion in this program of all neuropsychiatric patients who do not require closed ward care or intensive individual therapy.
- b. Experience has shown that a majority of patients with psychoneurosis are benefited by the prompt institution of a planned program which prevents the development of apathy, resentment, over-concern and the opportunity for symptoms to become fixed.
- c. It is expected that the establishment of such a program for psychoneurotic patients will not only be helpful from a treatment standpoint, but will also provide a means of caring for the increased numbers of patients by the limited trained personnel that is available. The use of personnel other than neuropsychiatrists will make it possible to conduct group

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activities which have been found to have a beneficial psychotherapeutic effect. A reconditioning program for neuropsychiatric patients will conserve manpower through rehabilitation, and the movement of patients out of hospitals into the program will make available more beds for those who require definitive hospital treatment.

(. . .). In general, it is expected that the greater part of neuropsychiatric reconditioning will be done in centers which have been designated for this purpose (. . .). At least one facility is planned for each service command, and the following have been already been designated: (. . .). First Service Command, Lovell Hospital Ft. Devens, Massachusetts." <sup>2/</sup>

In accordance with this circular and other army directives, the Neuro-psychiatric Reconditioning Facility was officially set up on 15 July 1944. Although it was still technically under the jurisdiction of Lovell General Hospital, it was separated not only physically but largely administratively. It had a professional staff of one chief psychiatrist, a chief psychologist and six psychiatric social workers. The Neuro-psychiatric Section was in actuality a Convalescent Section because the patients were cleared through Lovell General Hospital. Thus the patients represented "selected" cases screened by the psychiatric staff of the General Hospital. During the period from July to December 1944 the facilities and staff were fully adequate to care for for the patients

<sup>2/</sup> T.B. Med. 80 War Dept. Technical Bulletin: Reconditioning Program for Neuropsychiatric Patients, War Dept. Washington 25, D.C. Aug. '44.

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The policy was changed in January 1945, and the cases referred were no longer "selected". From this date all types of patients including the psychopath were referred to the Convalescent Hospital for treatment.

This change in policy began to be reflected in the rapid increase in the number of patients which reached five hundred in February. The hospital was transferred in this month to Camp Edwards, Massachusetts, where it was a separate administrative unit. The number of patients grew rapidly until they reached a peak of over three thousand. Although the professional staff also increased very rapidly, it had great difficulty in coping with the large number of the patients. From about July 1945 the Neuropsychiatric Section of the Convalescent Hospital decreased in size at an even faster pace than it had increased until it finally went out of existence as a separate unit in February 1946.

### Structure

The chart on page 10 will give a fairly good idea of the structure. The section was set in typical fashion under a Chief Psychiatrist with a central headquarters. Under him were all the psychiatric, psychological and administrative

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The psychology section, of which the psychiatric social worker was a part, had a chief and assistant psychologist in charge as well as a clinical psychologist in each company. The latter supervised the work of the psychiatric social workers of whom there was one in each barracks. This section had from about February 1945, a "Psychological Laboratory" for the purpose of giving psychological tests. This was under the direction of an officer psychologist and was staffed by four WAC and four civilian women.

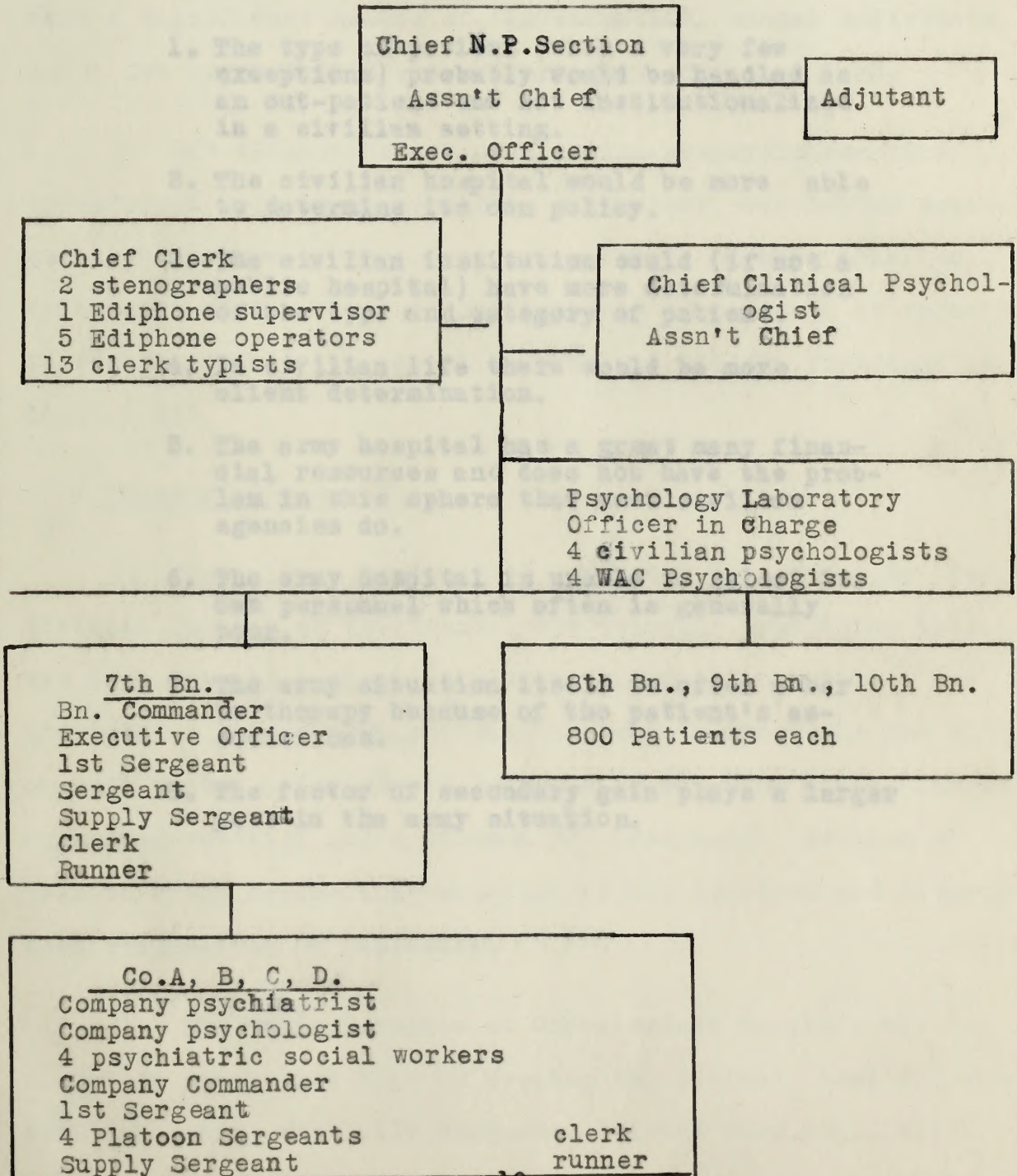
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## CHAPTER II

### CLASSIFICATION AND DISTRIBUTION OF PERSONNEL

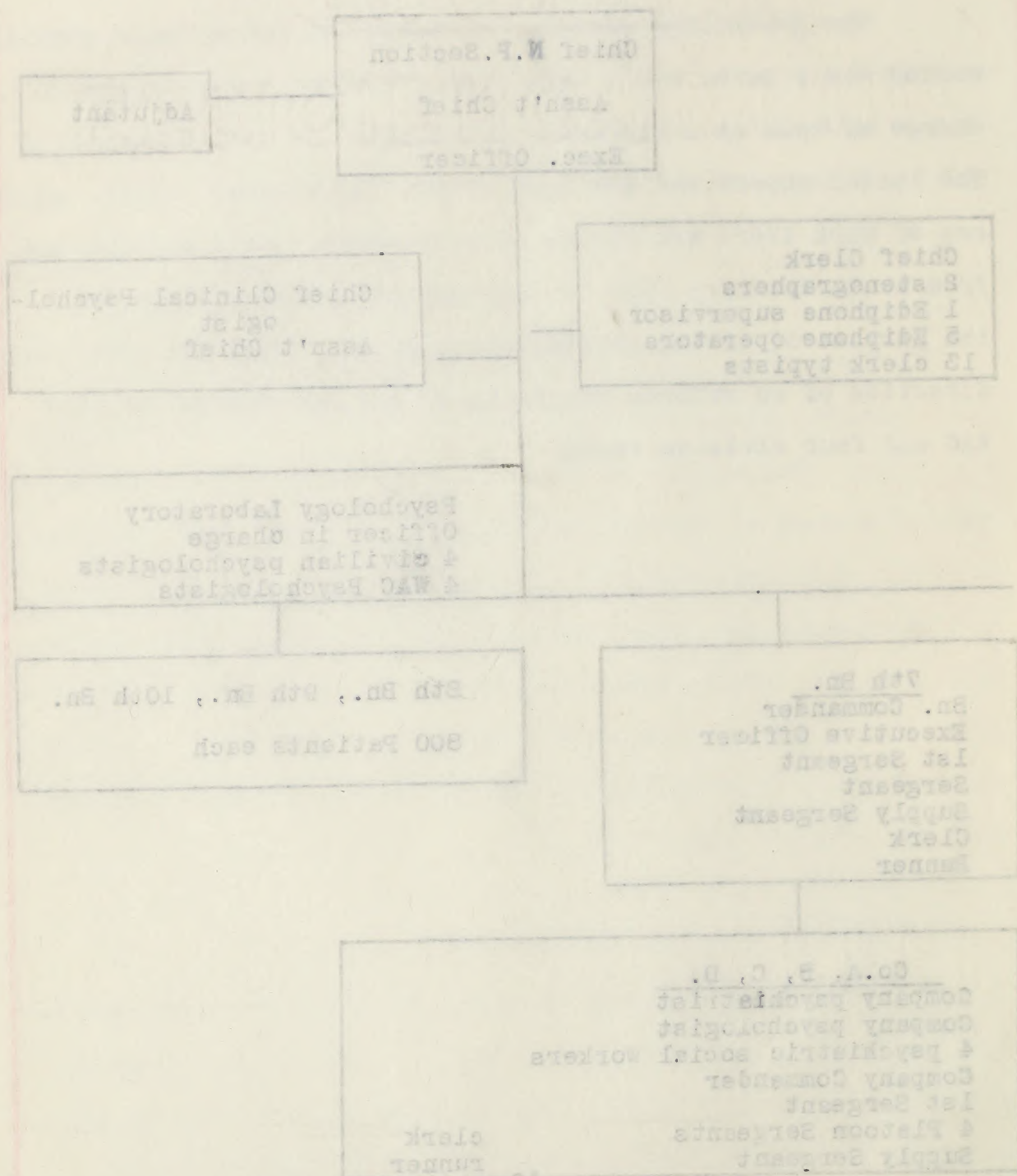
(In the Neuropsychiatric Section)



# CHAPTER II

## CLASSIFICATION AND DISTRIBUTION OF PERSONNEL

(In the Neuropsychiatric Section)



## Differentiation from a Civilian Hospital

There are several things that differentiate this from the "average" civilian hospital.

1. The type of patient (with a very few exceptions) probably would be handled as an out-patient and not institutionalized in a civilian setting.
2. The civilian hospital would be more able to determine its own policy.
3. The civilian institution could (if not a public hospital) have more determination of the type and category of patient.
4. In civilian life there would be more client determination.
5. The army hospital has a great many financial resources and does not have the problem in this sphere that most civilian agencies do.
6. The army hospital is unable to select its own personnel which often is generally poor.
7. The army situation itself is often a bar to therapy because of the patient's associations.
8. The factor of secondary gain plays a larger part in the army situation.

The daily schedule at Convalescent Hospital was designed to counteract this by keeping the patient busy all the time and making available adequate leisure time activities.

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### Types of Cases

As was mentioned earlier, the cases were unselected and supposed to be all "psychoneurotics". Actually there were a significant number of "psychopaths", mental deficientes and a few prepsychotic and epileptics in our case load.

The epileptics and usually the prepsychotics were transferred to general hospitals where they were better equipped to take care of this type of patient. A more detailed discussion of the other classifications of patients in relation to treatment and with case illustrations will be presented in Chapter III.

### Types of Treatment

There is a tendency to consider only group or individual therapy as treatment; but actually everything that was done for the patient (including his daily schedule) was treatment. The average patient had been in hospitals for six or more months often merely lying on his bed or having little organized activity and a minimum of treatment. Because of this he often became too conscious of his symptoms and disgruntled and hostile or depressed.

The daily schedule at Convalescent Hospital was designed to counteract this by keeping the patient busy all the time and making available adequate leisure time activities.

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The daily schedule at Convalescent Hospital was designed to counteract this by keeping the patient busy all the time and making available adequate leisure time activities.

It included athletics, orientation, an educational program (with wide choice of classes including music lessons on a variety of instruments), occupational therapy and group therapy.<sup>3/</sup> This was well spiced with trips to go swimming, see plays, attend the circus, and take tours to various places of interest. The army took over an island for swimming and sports, and a country club which had a golf course, private beach, boating, tennis and other sports. At the latter place there were nightly steak dinners and dances.

The Special Service Section of Convalescent Hospital was quite efficient. Therefore in addition to the usual camp movies and service club, there were activities every night including vaudeville, wrestling, dances and parties.

Psychotherapy took two forms: group and individual. In the early stages of Convalescent Hospital sodium amytol was used as an aid to treatment with conflicting results. This may have been partly due to lack of experience of those conducting it. The methods used during the period under study were those of the clinical psychologist as well as the psychiatric social worker and included the face-to-face interview, free association, dream analysis, hypnosis and hypno-analysis. The approaches included the Meyerian, Freudian, Rankian and psychobiological. (The methods of approach used by the writer

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will be discussed with illustrations in Chapter III.) In any case the goal in all methods and techniques was to restore the patient to a level of adjustment at least approximating that which he had prior to induction and to give him some insight into his condition.

# PATIENTS' DAILY SCHEDULE

Camp Edwards General Hospital 1945 - 1946

TIME	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
0600 0645		0600 0645	0600 0645	0600 0645	0600 0645	0600 0645
0700 0745		0700 0745	0700 0745	0700 0745	0700 0745	0700 0745
0800 0845		0800 0845	0800 0845	0800 0845	0800 0845	0800 0845
0900 0945		0900 0945	0900 0945	0900 0945	0900 0945	0900 0945
1000 1045		1000 1045	1000 1045	1000 1045	1000 1045	1000 1045
1100 1145		1100 1145	1100 1145	1100 1145	1100 1145	1100 1145
1200 1245		1200 1245	1200 1245	1200 1245	1200 1245	1200 1245
1300 1345		1300 1345	1300 1345	1300 1345	1300 1345	1300 1345
1400 1445		1400 1445	1400 1445	1400 1445	1400 1445	1400 1445
1500 1545		1500 1545	1500 1545	1500 1545	1500 1545	1500 1545
1600 1645		1600 1645	1600 1645	1600 1645	1600 1645	1600 1645

4/ Roughly accurate as to amount of time spent but actual hours may vary.

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PATIENTS' DAILY SCHEDULE

4/

Camp Edwards General Hospital 1945 - 1946

HOURL	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
0800 0845	O C C U P	A T I O N A L	T H E R A P Y			
0900 0945	O C C U P	A T I O N A L	T H E R A P Y			
1000 1045	P H Y S I C A L	T R A I N I N G			INSPECTION	
1100 1145	P H Y S I C A L	T R A I N I N G			INSPECTION	
1200 1330	M E S S	M E S S			S	
1330 1415	ORIENTATION	CO. ADMIN.	ORIENTATION	CO. ADMIN.	P	
1430 1545	P H Y S I C A L	T R A I N I N G			A	
1600 1645	G R O U P	T H E R A P Y			S S	

4/ Roughly accurate as to amount of time spent; but actual hours varied.

Самостоятельно составил 1942 - 1946

EVANS, DICK SCHMIDT

## CHAPTER III

### ROLE OF THE PSYCHIATRIC SOCIAL WORKER

#### War Department Definition

In June 1945 the War Department put out a rather comprehensive document on the psychiatric social worker outlining the types, classifications, duties, standards of practice, relationship with Red Cross as well as instructions for the administration and supervision of the psychiatric social work program. (The writer became aware of this when he received the November issue of The Compass.) I will quote in part from this:

2b. The SSN (army job) qualifications require the individual to have a graduate degree in social work from a recognized school in social work, or at least two years supervised experience in social work activities in a private or public agency.

#### 3. Duties of Military Psychiatric Social Worker.

2. Under authority delegated to him by the neuropsychiatrist, the military psychiatric worker:

- (1) Obtains information from army units; presents history material or interview content for the neuro-psychiatrist, so that diagnosis, treatment and disposition are facilitated.
- (2) Will, under the direction of the psychiatrist interpret the findings and/or the program of the psychiatric unit to agencies or persons concerned, such as other medical

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personnel, unit commanders.

3. Will have the responsibility to explore and initiate effective use of opportunities and facilities within the army structure, to aid in the solution of the patient's problem.
4. Aids in the reorientation of the soldier to his problem, making such recommendations for, and reports of, treatment and disposition to the psychiatrist as may be pertinent and possible.
5. Will assist, when directed, with group therapy, preventative psychiatry, or other programs for which the neuropsychiatrist is responsible.
6. Will aid in administrative proceedings, including the preparation of necessary records, and reports, schedules and other related activities. 5/

A job classification manual which outlines each man's job included under the duties of the psychiatric social worker, the job of conducting group and individual therapy under psychiatric supervision and administering and interpreting psychological tests.

This is the theory, what is the job in practice?

### Role in practice

In view of the fact that the role of the psychiatric social worker in civilian agencies is ably discussed in the literature, remarks here will tend to emphasize differences

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in function. The nature of the setting and the limitation in number and training of personnel made it necessary at the outset for the worker to assume some of the duties that are more commonly attributed to the psychologist. He gave varied intelligence and personality tests to his patients including the Army-Wechsler, Kent Emergency Test, Shipley-Hartford and the Minnesota Multiphasic Personality Inventory. It was helpful experience in learning the value of these techniques as aids in diagnosis and treatment. Although during the period under study this function had been assumed by a separate testing section, the knowledge gained previously was of great value in proper utilization of the results in the total situation.

What was stated about testing can also be broadly applied to vocational and educational guidance. Thus, although this function was also absorbed by a newly created section operating at the time of this survey, the worker had attained a good working technique of both the theory and practice involved in this. The knowledge of the necessity of correctly integrating this (especially in selected cases illustrated in Chapter III) with total treatment plan was a valuable outgrowth of this earlier experience.

Although it can be stated that in the period under study the psychiatric social worker returned to the psychologist duties that are conventionally considered his, there was not as clear a relationship with the psychiatrist. The short-

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age of trained psychiatrists was actually acute even in peace time. With the vast increase in need due to the impact of the war, the army in common with civilian agencies found itself with a dire shortage of trained personnel. As a consequence men who had recently graduated from medical school were given about a three months course in psychiatry and then often placed in assignments that called for much experience. Many of these men were uninterested in psychiatry and their work reflected this while others did excellent jobs in spite of their limited training. Thus many psychiatric social workers, except for lacking medical training were better equipped than many "army psychiatrists" to conduct a plan of treatment with neuropsychiatrist patients. In addition the psychiatrist was usually deeply involved in "paper work". This was mostly because of necessity, but there was in addition an undeniable degree of rationalization for lack of participation in treatment. Thus most of the treatment was left to the psychiatric social worker and the psychiatrist in many cases was utilized mainly for his medical knowledge and to reassure the patient. In some cases he could be referred for treatment or consultation to the chief psychiatrist or one or two qualified members of the staff providing of course that the time was available.

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tients. During their six to eight week stay at the Convalescent Hospital, he saw them under all conditions and participated in many of their scheduled as well as leisure time activities.

What then did the psychiatric social worker do at the Neuropsychiatric Section of Camp Edwards Convalescent Hospital during the period under study?

- (1) He conducted individual and group therapy under supervision of the psychiatrist and psychiatric social work supervisor.
- (2) He took a social history, wrote a final summary, and filled out certain forms for each patient.
- (3) He recommended psychological tests when needed.
- (4) He attempted to know the men in his barracks, those needing help, and tried to be aware of morale and the factors affecting it.
- (5) He interpreted his section and its function as well as the patients and their needs to other individuals with whom he and/or the patients came in contact.

Due to the pressure of time and a case load which at times reached seventyfive in the six to eight weeks that the average patient was available for treatment, the number of patients who could be given individual therapy was limited to from fifteen to twenty percent of the case load. The opportunity for ten or more interviews with any given patient was rare. The number of official contacts even in individual

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treatment cases was usually about five (including obtaining information for the social history and final summary) and often only two.

On occasion it was necessary to spend time with some patients mainly because of their effect on group morale. In view of the time factor, however, the attempt was made to select cases on the basis of need plus probable success.

### Group therapy

One of the main functions of the psychiatric social worker was to conduct group therapy. At the outset when there was less pressure of time and a high case load, group therapy conformed to the conventional pattern. The men were divided into groups - combat incurred, those with a definite civilian history of emotional disturbances, the mentally deficient and the psychopath. The groups contained about eight to ten patients and met about three times per week for a period of about six weeks. The results of this in conjunction with individual therapy were highly satisfactory.

In the period under study which is more typical of the army experience, the same problem involved in individual therapy were felt in group therapy. With the increase of the case load to from fifty to seventy-five patients, "group therapy" became almost the sole method of "psychotherapy" for from eighty to eighty-five per cent of the patients. The term as used in this paper, although including the broad-

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What then was the group therapy program? The patients were divided into groups of fifty, each in separate barracks. These groups were unselected and usually contained a complete cross section of the case load. The psychiatric social worker who lived in the barracks with the patients administered the group therapy program under the supervision of a clinical psychologist. The men assembled in the upper floor of the barracks where they sat on foot lockers or their beds. Attendance was compulsory as this was stressed as an important part of treatment.

The talks were based on a series of mental hygiene lectures prepared by the staff. Although there was a very definite form for both the talk and the questions, the psychiatric social worker was discouraged from delivering this verbatim either by reading it or from memory. It has been the writer's experience that both the material and the method of delivery

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had to be adapted to his own personality as well as to the group. For this reason he may get the desired ideas across more effectively by devoting the entire session to a question and answer period. He would attempt to prepare the group for succeeding sessions by giving the group a feeling of participation in selection of the topics.

There were many reasons for the preparation of the lectures. One of the purposes was to convey to the patients the psychosomatic nature of their illness and to help them achieve insight. These talks covered a discussion of nervousness, anxiety, emotions, psychosomatic disorders, motivation, learning and habits, and treatment.

In the first lecture, we tried to prevent some of the building of increased anxiety by explaining why the patient is here and what he can expect. An attempt was made to lay a healthy basis for participation in the program by stressing the co-operative effort that is essential for cure. The lectures were developed toward reducing the tendency toward "secondary anxiety" (trying to prevent the anxiety over his symptoms from creating a new set of symptoms by excessive worry). We also tried to lessen the incidence of "guilt feelings". The emphasis on the cause of the patient's difficulty, rather than on the symptoms, helped emphasize the patient's share in the treatment program. It enabled us to combat the feeling that the doctor has some magic cure and "I'm a pscho,

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"I'm not responsible for what I do."

At the beginning the lecturer often found himself facing a blank wall or a great deal of hostility. This could be quite threatening at first. When the worker understood the psychological reasons for this and was able to "work it through" for himself during one or two cycles, he usually became able to handle this. He learned to avoid being pedagogical or professional or talking down to the patients; but rather to be "one of the boys" who can use plain simple speech frequently spiked with humor and illustrations. Being in a position to know the problems and points of confusion in his barracks as well as the morale, he learned to adjust his talks accordingly. (Some men used rather dramatic demonstrations of hypnosis and suggestion. The writer feels that this was not necessary and often laid the basis for a relationship which was not conducive to group therapy).

Although the groups were very diversified in many ways, the fact that they were all enlisted men gradually gave them a feeling of identity. The value of the group was very ably expressed by the late Paul Schilder when he said:

It is obvious that an individual in such a group sees the fundamental identity of his problems with the problems of others. It takes him out of the isolation into which the neurosis has led him. The members of the group easily identify with each other. The fact that one member of the group brings forward material which another very often tries to hide lessens

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the resistance and brings forward conscious as well as "unconscious" material. Frequently it is easier to see one's own problem when it is brought forward by another.....It is expected that the meaning of any detail of an individual's life history will be better delineated if brought forward in a group and appreciated by a group.-/

This was clearly indicated during discussions of "fear". Most soldiers will admit that they were scared in the army situation at times. Some will profess a complete absence of this feeling, however, and a few will be able or willing to place this at the time of its inception. This is often due to "guilt feelings". A discussion of this subject will enable many men to understand and begin to accept the relationship of their feelings and conflicts with the other "G.I.'s" in the group. This helps them to discuss their experience and reactions in the group or in the interview and to see them in a more objective manner.

In group living such as this rumors spread quickly and often with disastrous effects on morale. It has proved very helpful to have a "gripe" session about once a week with one or all of the following present: administrative officer, psychologist, psychiatrist. This not only has the value of catharsis; but also frequently clarifies misunderstanding that might interfere with the therapeutic process. The presence of these officers is helpful because of the fact that they may be able to supply additional information to clarify a problem,

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The staff has found that even though it might be difficult to answer some of these questions frankly and honestly, it is the best method in the long run. It was not advisable to attempt to play a "Dr. Anthony" or the part of a prophet even in an attempt to bolster morale. This was illustrated by the patients' frequent questions as to how long they would be at Convalescent Hospital. Since there were so many unknown factors involved, most of us would be quite frank in saying that we didn't know and merely state the time previous groups have spent at Convalescent Hospital. Some would give definite dates on the basis of what they felt was reliable information. When the time was reached and the patients were still there, morale often became quite bad. Trying to handle this situation by additional promises only aggravated the situation further. In one instance the effect of this (plus other factors) caused a situation where much damage was done to a barracks and the psychiatrist verbally abused and threatened with violence.

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It was observed that when emotional pressure lessened, hostility and aggression correspondingly lessened. This was particularly noticable during the war when, in spite of the fact that we quoted military regulations to the contrary, many men were very much afraid of being sent overseas and in combat again. With the end of the war and an army policy under which we could in practice discharge almost every man, there was more of a feeling of security. As a consequence the amount of hostility and aggression decreased markedly.

In delivering the lecture and conducting the discussion, we attempted to notice individual as well as group reaction to the material. In discussing the effects of heredity and environment upon emotional disturbance, the writer noticed one patient was particularly disturbed. In an interview made on this basis, it was discovered that the patient's mother and an aunt were in mental institutions and he greatly feared for his own sanity. We were able to work through these fears which had been revealed by the discussion.

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in the sphere of marital relations which often could be somewhat relieved by additional general discussion as well as in private interviews.

As the program progressed sessions could often be used as a springboard for increased socialization for some "shy" members of the group. Their ego was often strengthened by encouraging their participation (at the right time) in the discussion. Gradually some participated more and more in the sessions frequently volunteering their contributions and gradually experimenting with this "new gained confidence" in many spheres for new social experience. In one situation an intelligent psychopath, who was uncooperative and threatened to disrupt the whole program was given some responsibility as an assistant barracks chief and acquitted himself well. It was felt a good morale factor to let the men vote on various things affecting them, such as an order of disposition and when lights were to be turned out at night.

#### Background material

The case presentation that follows is an attempt to show a cross section of the case load: two cases of men who were not overseas, two cases that apparently were not psychoneurosis, two cases of feeble-minded (or borderline) patients, two examples of constitutional psychopathic state, two examples of conversion hysteria, and two representing anxiety plus physical symptoms.

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It might be said by way of general introduction that the patients from overseas had been hospitalized for at least six months before reaching Convalescent Hospital. As mentioned before, they usually had received little or no treatment or attention partly due to the pressure of "more pressing cases". In other cases, the wrong type of treatment had been used. They had been moved from one hospital to another and usually the anxiety and confusion heightened and the symptoms began to be fixed. Then too the factor of the dubious reward of recovery was return to duty and thus this factor of secondary gain colored the picture.

Although a record from overseas usually accompanied the patient, it was suspect. Because of the difficulty in getting a good civilian history in time to be of any value, the information obtained was largely from the patient. Because of this and due to other factors there was frequently a question in the worker's mind as to the possible physical basis. In "orthopedic and back" cases there were frequently questions of the proper evaluation.

Another factor that the social worker had to contend with was the "civilian attitude". Frequently the patient would respond well to treatment all week and then go home on a pass. When he returned on Monday morning he would frequently be in worse condition than when he left, or extremely hostile. This was largely due to two factors. One was "coddling" the

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Another factor that the social worker had to contend with was the "civilian attitude". Frequently the patient would respond well to treatment all week and then go home on a pass. When he returned on Monday morning he would frequently be in worse condition than when he left, or extremely hostile. This was largely due to two factors. One was "cobbling" the

patient and telling him his work was all done. The other was a lack of understanding of the patient and his symptoms which resulted in fear or uneasiness on the part of the patient's family. This was related to the fact that the individual involved could neither understand nor adjust to the home situation.

Before we discuss the individual cases, perhaps some brief general comments in background leading up to the patients' hospitalization would be of value. The problem of induction (or enlistment) is a very traumatic experience for most individuals. It means separation from family and friends, job, business, and/or education, privacy, comforts, freedom and various degrees of self-determination. It means a regimented existence with almost a total loss of civil liberties, a forced adjustment to crude group living and many unpleasant associations, frequently doing a job which he dislikes and for which he is untrained, continual uncertainty, taking orders, having heavy physical demands made upon him, and having his life regulated in every minute detail. Added to these emotional and physical pressures is the problem of motivation. Democracy did a poor job of propoganda. Many men did not know what they were fighting for. Few had a grasp of the issues involved. With few exceptions the men were most concerned with getting the job over quickly and going home. Many questioned (and some quite validly) why they had been accepted by the draft board. In some cases it appeared the man should

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have been left in civilian life on the basis of previous psychiatric or medical history, age, home problems, or job essentiality. These men with few exceptions had some civilian history of emotional difficulty even though it seldom had been disabling.

During basic training with its vigorous physical and emotional demands, many men began to have problems, mainly those referable to the gastro-intestinal tract, insomnia, anxiety, foot and back trouble, and fainting spells. In many of these cases the symptoms subsided until the organization began to be prepared for overseas duty. In these instances, the symptoms mounted in proportion to the threat. In many cases there were frequent visits to "sick call" and hospitalizations.

Since each person has his own "breaking point" based largely on his individual background plus the rigors he faces in army life, "breakdown" occurred at all stages in his army career. One of our patients was a "psychoneurotic casualty" on his third day in the army and never participated in active duty. In other cases this happened in basis training, on maneuvers, on the job in the states or overseas, under actual combat, sometimes after the first day and sometimes not until after six months.<sup>8/</sup>

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<sup>8/</sup> Our case load with few exceptions consisted of overseas men.



Combat is the supreme test of a soldier. Here was the final testing ground; the point where all the rigors of army life were heightened. To this the threat of death was added. With all training in civilian life having been focused upon sanctity of human life plus a lack of feeling of motivation on the one hand balanced in various degrees of loyalty to the group and the need for acceptance on the other, the conflict was intense. It was, as one patient said, "a feeling of being trapped; you wanted to run, but you were afraid of being killed by your own buddies. If you went forward there was even more danger of being killed".

The neurotic solution to this conflict which he could not tolerate were these symptoms which furnished a means of escape from an intolerable situation. Not only did they serve the purpose of removing the patient from combat, they were insurance to keep him from returning to battle, brought him back to the States, and furnished a basis for discharge. Thus this factor of secondary gain was always present and an obstacle to treatment.<sup>9/</sup>

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## CASE PRESENTATION

### Introduction

Although the cases described in this chapter may not conform to the exact book classifications, they nevertheless represent a typical cross-section of the case load at the Convalescent Hospital as diagnosed by the psychiatrists.

They fall into the general headings as follows:

Conversion Hysteria	2 examples
Psychoneurosis "mixed type"	2 examples
"Situational Reactions"	2 examples
Borderline Intelligence	2 examples
"Constitutional Psychopathic State"	2 examples
Men Who Broke Down in the United States	2 examples
Possible Psychotic	1 example

They were selected because they represent not only in psychiatric classification but also in civilian and army history and background a fair and representative sample of the total case load as well as the treatment methods and problems of the writer.

While it was necessary for various reasons to eliminate process from all the examples except one, an attempt has been made to give an accurate though brief summary of the interview situation. The case of Andre is given in some detail to illustrate the reactions of the patients and to give an example of the case work involved. There were several common fac-



tors involved in the problem and procedure of treatment in all these cases which were as follows:

1. Each case was discussed with the case work supervisor, who usually had also seen the patient, as to the type of treatment advisable and the results were carried out as far as possible.
2. The fact that the overseas records were often incomplete or inaccurate in the light of the current situation made it necessary to use them critically.
3. The structure and function of the Neuro-psychiatric Section of Convalescent Hospital often seemed confused and necessitated even more than in the average civilian case work agency a constructive appreciation and use of function and limitation. This meant also that attention was focused almost entirely on the present problem.
4. There was, except in the case of the psychopaths, a quick establishment of rapport and yet not an identification with the patient's gripes.
5. Blood tests and x-rays were given to all patients and other tests performed where indicated. Therefore unless otherwise indicated it can be considered that no physical basis was found for the patient's complaints..

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treatment reflected the tools and techniques of all. It was felt therefore that it might be helpful to define the following technical terms as they were understood by the writer in terms of their use in this paper:

### Anxiety

"In anxiety the emotional factors involved have physical effects on the body and it reacts as "fear". The difference is that "fear" is a reaction to something in the 'real' world; anxiety is a reaction that seems unjustified or out of all proportion to the danger that apparently is involved. This description is further complicated by the fact that, in anxiety, even though the emotional response itself may be conscious, the situation that arouses it may be completely unconscious (. . .). It always contains an anticipated helplessness, worthlessness, humiliation or injury. That is, it includes a state of anticipation of disaster or catastrophe, as well as emotions of self-condemnation, guilt, and so on" 10/

### Catharsis and abreaction

"It has allowed the individual to talk out his problems to an individual who provides a certain type of defined acceptance (. . .). We have learned that catharsis not only frees the individual from those conscious fears and guilt feelings of which he is aware, but that continued, it can bring to light more deeply buried attitudes which also exert their influence on behavior." 11/

### Ego support

As used in these cases, by "ego support" is meant the bolstering of the patient's self-esteem. This is often necessary where the patient has a deflated idea of his worth and is accomplished by means of attempting to give the patient a better appreciation of his own personality strengths.

10/ A.H.Maslow & Bela Mittelman, Principles of Abnormal Psychology pp. 57-58

11/ Carl R.Rogers, Counseling & Psychotherapy p.22.



### Guilt feeling

"Conflict may arise (. . .). as a reaction to past actions, to deeds already done. Such conflict always involves ideals, codes of ethics moral feelings, and the like, all of which have been summed up by Freud under the term "super ego". More commonly this is phrased by the layman as 'being bothered by your conscience'.

"When we do something we consider wrong or mean or nasty when we commit a crime or a sin or do something that conflicts with our ideals, then there arises in us a feeling of guilt or self-punishment." 12/

### Hostility

This is essentially a fear reaction and reflects this and insecurity. "I am in danger in various situations, but I shall be safe and able to carry out my goals if I successfully attack and incapacitate my adversary."13/ This device may show itself in concrete acts of destruction.

### Insight

Insight is the understanding of our acceptance of self. The aim in treatment in this situation is expressed by Grinker and Spiegel, when they say, "If he (the psychoneurotic patient) is going to master this situation (his neurosis), therefore the individual must clearly realize how it affects him (. . .). He must understand his own anxiety, and what he can do about it. The aim is to establish a very simple and practical insight which recognizes the biological importance of anxiety placing it in the sphere of reaction which everyone can control".14/

### Persuasion

"In this method, the physician tries to clarify the development of the symptoms, their relation to situational and personality difficulties;

12/ Maslow & Mittlemann op.cit.p.139

13/ Ibid, p. 161

14/ Roy R.Grinker & John P.Spiegel, Men Under Stress p. 158

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12. Mallow & Mittelmann op.cit. p.132

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and he explains to the patient the inter-relations of these factors and how this difficulties can be overcome (. . .). Persuasion is a method of carrying conviction that aims to prompt the acceptance of a point of view."<sup>15/</sup>

### Reassurance

Reassurance is used in the sense that the psychotherapist may "have certain information that he can use as a reassurance, in alleviating some of the patient's anxieties (. . .). to reassure a patient who has neurotic insanity panic that the patient is not psychotic but rather has an anxiety neurosis (. . .). to reassure a patient that he need have little anxiety over the fact that he has a psychotic cousin.

". . .). The patient from such a reassurance received not only the logical effect of being able to combat his anxieties by some new facts which contradict his anxieties. He receives also an emotional effect from the reassurance. It has an effect, as has medication, which is based on its being a sign of security, friendliness and dependability from an important person in his world (. . .). One of the chief differences between the psychoanalytic psychotherapy, is that other forms use reassurance about secondary anxiety as a large component of their treatment, whereas the psychoanalytic form of psychotherapy attempts first to uncover the original anxieties and then give reassurance about them."<sup>16/</sup> In this paper it is used in the sense of relieving secondary anxiety.

### Suggestion

People tend to accept the ideas and attitudes of others. The therapist, because of his relationship of acceptance of the patient, helpfulness, understanding, plus some authority often has directed toward him some of the positive feelings that the patient had toward his parents in childhood. This relationship is used in some very carefully selected cases in this paper urging

<sup>15/</sup> Maurice Levine Psychotherapy in Medical Practice ppl25-126  
<sup>16/</sup> Ibid pp.40.41

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### Transference

"By the transference we mean the tendency of human beings to transfer to new objects and to new situations those emotions and attitudes which they have toward the important figures in their past lives. The positive feelings toward the physician (or other therapist) after the confessional periods (catharsis) is an example of positive transference. The physician (or other therapist) by his willingness to listen and to help, has become the object of the strong positive feeling which in childhood developed toward a good father or mother who was the original source of security."<sup>17</sup> While in the situation described in this paper, the relationship might not be so deep and strong, it was quite similar to this.

### The case of Andre M.

Andre was a twenty-three year old, white single Private First Class with four years of service of which three and one-half were overseas. He had five months of service in the European Theatre of Operations. Patient saw action in Sicily, Italy and Normandy with the 82nd Airborne Troops. In the Normandy invasion he suffered a "bad blast injury" but continued his duties. A few days later, in the early daylight two companies were seriously wounded in the battle approaching St. Lo. Andre dragged them to a hedgerow as the area began to be filled with Germans and the mortar shells landed closer and closer. Then retrograde action set in for a period of two or three hours. Patient remained in combat seven or more days and then was hospitalized in July 1944 because of marked anxiety symptoms. After two and one-half months of hospitalization he was reclassified and assigned to Army Police. From this time until his present hospitalization on June 14, 1945, he spent most of his time in replacement

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# 1. Two cases of psychoneurosis, mixed type

The two cases shown here are examples of the symptom pictures we saw in most patients. A great deal of "pure anxiety" may have been seen in the battle areas and the hospitals in the theatres of operation. By the time the patients reached the Neuropsychiatric Section of Convalescent Hospital, however, the picture almost without exception included physical symptoms as well.

Because of the pressure of time, it was necessary to handle these cases in two scheduled interviews plus a few informal contacts for the purposes of a follow up.

## 2. The case of Andre M.

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Patient's father was "gassed in the last war, has a cough and sometimes passes out". His mother and two sisters are living and well. His other sister seems to have suffered organic brain damage and has been "out of her head" for several years and hospitalized because of this.

Andre had a "club foot" which apparently was operated upon successfully. He had enuresis until a kidney operation at the age of twenty-one. Patient finished the eighth grade of parochial school at fifteen and one-half years of age. He has had several jobs. For the one and one-half years before his induction he worked in a textile mill.

Andre came to Convalescent Hospital with the diagnosis:

Psychoneurosis, anxiety type, severe, manifested by depression, vague somatic complaints, anorexia, nightmares and startle reaction. There was a second diagnosis of mental deficient, moron type.

Because of the very limited number of interviews that were possible, it was necessary to establish a working relationship with Andre quickly and therefore a direct approach was warranted in the first interview. This was done by asking him how he felt at the present time. Andre responded readily and said, "Not so hot. I still can't eat much. I go into the mess hall hungry and when I sit down I can't eat. I keep dreaming and I'm nervous as hell. I'm grouchy and can't stick at anything, and blow my top easily. That (. . .). of a company commander we have keeps making it worse. How long

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do I have to stay in this place?"

Recognizing the anxiety and hostility Andre was expressing, it seemed advisable to tell him frankly that it was not possible to give him any stated time for his release. An attempt was made to give him some understanding of the reason he was at the Convalescent Hospital and the treatment relationship with the worker in the hope that this would help him gain confidence in the worker and give meaning to the interview. In reply to the explanation of the purpose of the interview which was to help him get better and get some of his feelings out of his system, Andre responded, "I've talked a lot about this stuff. The less the better now. (. . .). . ., I want to forget. Every time any one talks about it I run away. Don't remind me of it."

The worker recognized that the war experiences were too painful to Andre and he was making too great an effort to repress them. It was realized that unless he could talk more about them, there was little probability of his improvement. On this basis and feeling a sufficiently strong transference had been made to the worker, further effort was made to bring pressure upon Andre to talk about his feelings by asking direct questions, and at the same time attempting to develop his insight as to how "talking things out" might help. The analogy was made to a physical condition of the body when a per-

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son eats spoiled food stressing the fact that not only the stomach but the whole body becomes upset and medication is necessary to relieve the body of the poison. In the same way when a person's mind is upset by difficult and unpleasant experiences our entire body is upset and our feelings towards oneself and others gets "off the beam". If one can get rid of those feelings and attitudes it often helps and we feel better. Andre replied "That sounds O.K. to me, but how can I do it? You mean just sitting here and talking to you will help?" The worker replied that it might help and it certainly wouldn't do any harm.

The interview was terminated at this point as it was necessary for Andre to leave. The worker felt that in spite of some resistance on Andre's part that a good transference and understanding of the process of treatment had been obtained. The need for catharsis and reassurance and the fact that the former might have to be forced was indicated.

In the second interview the worker felt that the strength of the relationship would permit beginning at once with Andre's war experiences provided he was given adequate support, reassurance and understanding as the role indicated. He asked Andre directly when he first felt sick. Andre responded immediately, "It was during the Normandy invasion. I felt my luck would run out. There were only a few of us left." The worker expressed his understanding and used the

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familiar expression, "I guess you thought your number was up?" The patient stated this was true and seemed to talk more freely, yet became tense and began to stutter slightly as he related the following incident which brought him into the hospital. "When I awoke after the shelling I asked about them. They were my best buddies. Had been with them in Africa and Sicily and not a scratch and then, damn it, they almost got all of us at once. You don't know what it means, Sarge, you've got to see it".

The worker felt that the patient should not stop here, but be helped to talk through this experience, so encouraged this by saying, "You must have thought that it was the end."

Now that he had started to talk, Andre seemed eager to continue and stated, "I had said my prayers so many times it wasn't funny. The German eighty-eights kept getting nearer and nearer. One of those bastards got so near I could have reached out and touched him".

Again the worker felt the patient needed help to carry through the reliving of the memory by saying "That feeling of being trapped and not being able to do anything about it must have been terrible".

"You hit it on the head", Andre replied. "I was with two of my best buddies who were in bad shape and I could not do a thing. They needed a medic and I didn't get them one".

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With very strong emotion and tension which had been slowly increasing throughout the interview Andre said, "It was hell, I tell you, just hell. Do you think I was yellow, Sarge? Did I let them down? Should I have risked it?"

The worker felt that Andre had reached the peak of his emotions and that definite support with reassurance should be given to release his anxiety and strengthen his confidence in himself and therefore replied, "I don't see how you could have left those wounded buddies on a ten to one shot of getting through and not knowing you could get any help back".

Andre seemed to have been relieved to be able to express his guilt and at the same time be given acceptance. He was less tense and anxious and his voice assumed a more relaxed tone as he replied, "Well this kept bothering me and the shells kept coming closer and closer. I felt I couldn't go anywhere. It wasn't safe and I couldn't leave those guys. Well finally we were rescued. I felt O.K. the next day, only a little shaky and was in combat for seven more days and they got so bad they took me out of the outfit. I was really a wreck then."

At this point the worker felt it was wise to attempt directly to help the patient gain some insight into his reactions and relate his present illness to the experiences recounted and asked, "What do you think was the reason you felt that way?"

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At this point the worker felt it was wise to attempt directly to help the patient gain some insight into his reactions and relate his present illness to the experiences recounted and asked, "What do you think was the reason you felt that way?"

The patient replied, "I don't know. I guess it was what I was through. Until Normandy I felt nothing would happen to me. Then I got scared as hell. Before St.Lo when all the guys began to get knocked off, I kept waiting for my day to come. When my buddies got hit I thought it was the end of my luck. From then on I was more scared all the time."

The worker recognized he was forcing the issue with the patient but it seemed necessary in the situation. He took the clue from the patient and said "Do you think it was being scared and the experience you went through that made you sick?"

The patient replied, "I guess it must be because they examined my stomach and head and found nothing wrong. What you mentioned in your lecture seems to apply to me; but I still feel lousy. I don't want anything to do with people or to hear or see anything about the war." It was obvious that Andre was attempting to run away from his difficulty rather than attempting the more painful course of coming to grips with it. The worker felt that the patient must be made to accept the reality of the situation and his own share in the responsibility for getting well. He attempted to convey this idea to Andre when he asked "Do you think you can run away from these things? Aren't they a part of you?" This was followed with the suggestion that he could help himself by making an effort to do things with people, going out on

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dates and participation in sports. The difficulties involved for Andre were recognized by the worker saying "It may be painful and hard at first. It is like some medicine; it tastes bad but it is good for you."

The interview ended at this point but this was followed up in brief informal contacts and it appeared that EM was socializing more and his anxiety symptoms were disappearing.

It might be helpful to summarize the case to emphasize those factors that appear in most of the other cases.

Andre presented a picture of what was previously described as secondary anxiety in his worry about his symptoms. The apparent picture of hostility and frequent use of profanity were manifestations of this. He was frightened and puzzled by his illness and expressed his ambivalence about the feeling he needed help and yet not really being ready to accept it.

It was felt that treatment would be in the form of abreaction, reassurance, suggestion and attempting to give the patient insight.

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ful interpretation of function. Actually abreaction was forced and the patient talked about his experience around St. Lo which led to his hospitalization with a great deal of tenseness and some stuttering. It reached a peak when with a great deal of tenseness he asked, "Do you think I was yellow, Sarge? Did I let them down?" In places like this, reassurance by the worker, a fellow "G.I." meant a great deal and helped reduce the anxiety.

Although Andre's second diagnosis was mental deficient, moron type, it seemed that, especially after some anxiety was relieved, that the nature of his social responses, alertness in the interview situation and his actions in the various activities, raised a question about this. A Bellevue-Wechsler given on this basis revealed that Andre was of normal intelligence.

An attempt to develop in Andre some insight was done towards the end of the contact by such suggestions as "What do you think was the reason you felt that way?" and "You think it was being scared and the experiences you had been through that made you sick?" The patient was able to use these ideas and relate them to the Group Lectures in a way that showed some understanding on his part.

Suggestion was given at the end of the contact aimed at more activity which was followed up in a few brief informal contacts which seemed to show that Andre was socializing



more and his anxiety was subsiding.

### The case of Harry L.

Harry was a twenty-seven year old married Corporal, with four and one-half years of service, of which seven months were overseas in the ETO. He was an armorer for a rifle company and also in charge of bringing supplies to the platoons in the lines. On one of these occasions he was taken prisoner by the Germans.

Shortly before going overseas; patient had stomach pains and diarrhea which became steadily worse overseas. He had previously been hospitalized on two occasions—once for back injury and the other time for a rash on his face.

His mother is "somewhat nervous". A younger brother has "heart trouble". His wife and child are well.

Patient is the second of three boys. He had the usual childhood diseases. As a child he bit his nails, stuttered, had phobias about weapons of all kinds and headaches. Harry graduated from high school at eighteen and had various clerical jobs until his induction. He apparently made an average marital, social and athletic adjustment.

Harry has always disliked certain foods. He has had "stomach trouble" as far back as he can remember". Although he had medical treatment for this, it did not appear to be disabling.

Harry was a short, rather frailly built, dark complexioned soldier, who gave the impression of being burdened down by cares and had a marked facial tic. He appeared to be an immature, emotionally unstable individual with a marked predisposition (including a phobis about weapons) who might have

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broken down even without his capture by the Germans which was the traumatic experience. Since it was apparent that he was controlling a great deal of emotion, the worker felt that catharsis would be most valuable to the patient plus a little suggestion and ego support including counseling.

The establishment of a rapport, confidence, transference enabled Harry to release the obviously tight grip that he was attempting to keep on himself and he was able to cry, which worker felt was a good sign. The worker's acceptance of the positive aspects of this by means of reassurance prevented any guilt from arising. Therefore, the process of abreaction could continue and Harry was able to express his traumatic experiences. What it meant to him found expression when he said, "You know, I never told anyone about this... . I didn't think they would understand. It feels like a two ton weight has been taken from my head."

Harry's need for reassurance was expressed by such phases as: "Do you think I'll get back into shape, Sarge?" The patient was given the assurance that was justified in the situation plus suggestion for greater activity, sharing his experiences with understanding people, and not assuming too much responsibility.

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from the time he started to go overseas, using such leading questions as "How did you feel when your outfit began to be alerted for overseas?" The attempt was made to have Harry do as much of his own thinking as possible. This was illustrated by the answer to the patient's question: "Do you think nerves can cause this?" "What do you think?"

The positive results on the vocational counseling and the tentative plans for Harry to "better himself" by studying accounting were of value in the form of ego support.

#### Discussion of Mixed Type

These cases were different in several ways. Harry had a more neurotic background, was married and had one child, and apparently was superior to Andre in schooling as well as native intelligence.

These patients had many things in common besides a broad similarity in symptoms. They represent men with definite civilian personal and family histories plus a long period of intense anxiety coupled with a series of traumatic experience under which they bore up surprisingly well.

It is interesting to observe that they apparently made at least a borderline adjustment until the actual threat of death personalized.

It would seem that if Harry had been kept in the States rel-



actively near his home that his total value to the army would have been enhanced. If in the second case, in view of Andre's civilian history, he had been removed from combat after the first or second traumatic experience and reassigned, the ultimate situation would have been different. Of course, however, many considerations go into these conditions and it is difficult to predict the outcome in advance.

From the standpoint of treatment, the following factors were prominent:

1. These represent only two actual appointments of less than one hour each.
2. Other resources, such as group therapy, vocational counseling, the opportunity for observation by the worker, and the group experience itself, played a large part.
3. "Treatment" was largely on the basis of abreaction (forced in Andre's case) desensitization, reassurance and suggestion. An attempt was made to build on the little insight in each case to increase the beginning of the intellectual understanding of the illness.

## 2. Two Cases of "Late Maturing Individuals"

These two cases are not too readily classified. Although both of these men had civilian histories of poor adjustment and neurotic reactions to varying stress, the picture they represented when they were seen at Convalescent Hospital was "symptom free". They seemed more to be

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individuals who were apparently maturing late in life and were not able at present to adjust to the demands of their environment.

### The case of Tom

This case was handled in a series of eight interviews during a ten week period plus frequent observation and informal contact.

Tom was a twenty-one year old Private First Class with three years of service of which twenty-seven months were in the southwest Pacific. Although his outfit had several months of combat, Tom's experiences were limited by severe anxiety reactions which caused his being sent behind the lines and hospitalized on several occasions. In February 1945 two of his buddies were killed by a mortar shell which caused a "concussion" and precipitated his entry into the hospital and his evacuation to the United States.

Patient was the only child and was always treated as an invalid following childhood diseases. He was not allowed to participate in sports. Patient was strongly protected and shielded by his parents and was never given any responsibility. Tom was always shy and seclusive with a strong feeling of inadequacy and inferiority because of his lack of physical prowess. He had few friends and essentially no social life. These feelings caused him to leave school (where he had an average scholastic record) and attempt to learn the jeweler's trade. He was unable to become self-supporting after two years.

Having failed at this job, Tom made another attempt to prove himself by joining the army. This desire motivated him to attempt to do things he did not like or could not do. He was considered unfit for combat and was frequently transferred from one organization to another. He was hospitalized after having fainted on guard duty. Tom went AWOL from the hospital to join his unit. After being in the combat area for a few days, however, he was sent back to the area behind the lines "exhausted".

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Patient was the only child and was always treated as an invalid following childhood diseases. He was not allowed to participate in sports. Patient was strongly protected and shielded by his parents and was never given any responsibility. Tom was always shy and sensitive with a strong feeling of inadequacy and inferiority because of his lack of physical prowess. He had few friends and essentially no social life. These feelings caused him to leave school (where he had an average scholastic record) and attempt to learn the jeweler's trade. He was unable to become self-supporting after two years.

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When the patient reached this point in his social history he became very tense and seemed to lose control of himself. Since it was felt inadvisable to press the patient too much in the first interview, the conversation was shifted to a discussion of his very recent marriage and social activities. More recreation was suggested. Physically Tom was small and frail and almost feminine looking.

The worker was quite confused and wondered whether Tom had schizoid tendencies. The Bellevue-Wechsler (I.Q.116) Minnesota Multiphasic Personality Inventory, Shipley Hartford plus psychiatric examination, however, ruled out any marked abnormality.

Thus Tom presented the picture of an immature seclusive person who seemed to have been confused and bewildered by his army experience and having strong guilt feelings about some phases. It appeared that what he needed was greater integration of his personality and appreciation of himself. While it was realized that complete personality change could not be attained on the basis of the treatment at Convalescent Hospital, it was felt that perhaps a substantial start might be made in this direction by utilizing the program to build Tom's confidence and widen his sphere of activities and interests.

The aid of the physical training instructor, saxophone teacher (Tom was referred here because of his expressed interests) and barracks sergeant were enlisted in the treatment plan for observation and encouragement. The barracks sergeant added to the picture with his description of the patient as in a "perpetual perplexed confused state".

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The interviews showed a continual development of patient both in and out of the interview situation. Tom talked of being protected all his life. He was able to express his feelings about the need for success in the army and his sense of guilt as to his failure as a soldier. After some catharsis the worker began to give reassurance by discussing the fact that in view of his background that he had done well in the army. A good Bellevue-Wechsler score (I.Q. 116) and negative Minnesota Multiphasic Personality and Shipley-Hartford scores were discussed with the patient. An attempt was made to get patient to understand himself better and bibliotherapy was utilized as an added tool. One chapter from the "Psychology for the Returning Serviceman" was particularly apropos. At the same time an interview with the psychiatrist was used to add to Tom's ego support.

Not only was improvement noticable in the interview situation, and around the barracks, where patient seemed much less preoccupied and more a part of a social situation; but other reports also bolstered this impression. The physical training instructor reported that Tom was participating more and more in sports in spite of his lack of ability and some razzing by his fellow patients. The saxophone instructor was particularly impressed with Tom's "unusual aptitudes and ability". He also began to assert himself at home and much to his surprise and pleasure he "began to be accepted as an

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adult".

Perhaps the change could best be expressed when patient said in the last interview that he could feel himself getting better. "Say, you know, I am a new man. It's as if I started to live."

This shows on the part of the worker the necessity of recognizing the nature of the problem and his role. The patient received in this case acceptance not only as a man, but as a fellow soldier. This was the basis of the relationship. It showed the use of the function, structure and resources of the hospital not in a rigid, binding manner, but as helpful tools in the manipulation of the environment. There was real growth and greater integration of the personality and appreciation of self than the patient had previously achieved. Tom was able to understand that in spite of his difficulties the army did aid in his development and the treatment experience gave him the basis to appreciate this and the courage to begun to utilize this in his personal contacts. It can be said with objectivity that in this case the patient profited from his army career.

### The case of Henry

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#### The case of Henry

This is a case illustrating a situational reaction to combat. Treatment consisted of six scheduled interviews plus a few informal contacts.

Henry was a twenty-eight year old, single, white 1st Sergeant with six years and six months service. He served overseas for one year in the European theatre and had six months of combat in a tank destroyer company. In May 1945 he developed a fever of unknown origin and was hospitalized. While under treatment he developed insomnia, felt tired all the time, had a low back pain, mild headache, anorexia and was irritable. He was evacuated to the U.S. After a short stay in a station hospital he was transferred to Camp Edwards Convalescent Hospital. Here he was given a thirty day convalescent furlough and returned for treatment on 27 August 1945.

Patient's father drowned when he was eight years old. His mother is living and well. He is the fourth of seven children.

He seemed to have a normal athletic adjustment although his social adjustment was somewhat retarded. Henry denied any neurotic traits prior to induction. He had the normal childhood diseases.

Patient finished the eighth grade at sixteen and spent one semester in vocational school. Patient had various jobs of a semi-skilled nature, never staying at one for more than a year.

Henry was arrested a few times for "shooting craps". He joined the army in 1939 for an escape. Henry is about six feet tall and one hundred and ninety pounds and good looking in a manly way.

The impression was that Henry's main problem was that of immaturity, lack of self-confidence, and self-consciousness. It was felt that after a little catharsis, treatment could be most effectively directed in this area. Catharsis was concentrated on his responsibilities as First Sergeant especially in combat area and in actual combat. There was a



great deal of resistance at first which was complicated by patient's difficulty in relation to people. Rapport was finally established. Henry told how, because of the large amount of casualties among the officers and the inexperienced replacements, he had to assume a larger amount of responsibility than should have been his. The strain of this plus his feelings of guilt (he blamed himself for the high number of casualties) created the mounting anxiety. These tensions finally got out of control after Henry was hospitalized.

After being able to express this feeling and have them understood and accepted, Henry relaxed markedly. He was then able to reveal his confusion over his future plans with such terms as "I can't understand civilians. I would like to be on the outside but I am afraid. What could I do?" This was used to open a discussion of Henry's ambivalence about further service. The good results on the Bellevue-Wechsler (I.Q. 127) and vocational and high school achievement tests were discussed to bolster his confidence as well as demonstrate that he had a choice about the future even if it was more apparent than real.

Ego support was successfully attempted in a discussion of the fact that he had reached the highest non-commissioned grade in the army and his strengths, which were a "pleasant personality", good appearance, above average intellect, good mechanical aptitude, and an ability to handle men were discussed. (One of the indications of his overcoming his self-

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consciousness was his finally asking a WAC for a date after toying with the idea for three weeks). No attempt was made to influence any choice as to the patient's future, but rather to show that there was a real choice. When he left Frank seemed much more self-assured and with a better understanding of himself.

### Discussion of Two Cases of Late Maturing Individuals

These cases differed in the fact that Tom was given too much in the way of guidance and supervision at home while Henry was given too little. Tom lacked Henry's physical prowess and stature. The latter was a poor student in school and frequently played hockey while the former was a good conscientious student.

Both men had a poor job history and enlisted in the army as an escape and an attempt to prove themselves. In treatment they presented similar problems and called for a similar approach described as follows:

1. The two cases represented a use of a wide variety of participation in the treatment plan including the physical training and saxophone instructors, the case work supervisor, psychiatrist, vocational counseling (with achievement and aptitude tests) intelligence and personality tests and bibliotherapy.
2. Treatment was on the basis of catharsis, discussion of life history, bibliotherapy, reassurance, manip-

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3. Both men by discussion of their personality and through a better appreciation of themselves, seemed to show a better integration of personality than they probably had before their induction. In the case of Tom, who had some motivation in the form of a wife and a promising job and was seemingly able to support his "new personality" in his daily life, the prognosis seemed very bright. For Henry, should he decide to make the army his career (a reasonable decision in his case) could do so with the knowledge that he had a choice and more confidence in his ability.

### 3. Two cases of Men who broke down in the United States

This type of patient, because of the strain due to the factors necessary for adjustment to army life even in a routine job, often plus extenuating circumstances in the army environment and home situation and a family/or personal history of neuroticisms frequently broke down without having been overseas.

Early in the history of the Convalescent Hospital we used to see this situation often. Because of a change in army policy, however, during the major period of our study we handled only overseas veterans.

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Jack was a thirty-four year old married white private with one and one-half year's service. He trained in the combat engineers. Because of difficulty keeping up with the men in his outfit in hiking and infantry and rifle drill, he was assigned as a clerk. Patient was never overseas. He was hospitalized on three occasions because of complaints of insomnia, anorexia, tremors, tenseness and occupational headaches and eventually transferred to Convalescent Hospital for treatment.

Patient's father died at the age of fifty-seven of "heart disease". Patient described him as a "tense, nervous person". His living sister and brother are described as "nervous and high strung". One sister died of heart disease" and another as a result of cancer".

Jack is the second of the three living children. As a child he had phobias about the dark, heights and blood. He stuttered, had frequent nightmares, bit his fingernails, cried easily, had temper tantrums and had enuresis until eleven or twelve. He fractured his nose and suffered a head injury at an early age. Patient worked after school since the age of twelve and avoided athletic and social activities.

Jack completed High School at the age of eighteen; patient repeated the second grade. His work history is poor; the longest job being working irregularly as a shipfitter's helper for three years prior to his induction. He visited clinics in Pittsburgh on two or three occasions for vague somatic complaints. He had a strong feeling of inferiority, frustration and inadequacy.

His wife is under treatment at the Parson Clinic and his mother-in-law has been committed to the same clinic with "involutional melancholia".

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fusing picture of conflict and anxiety. He was greatly worried about the condition of his wife and mother-in-law and seemed unable to cope with this situation plus his own anxiety.

Although the patient's prognosis was poor for any short term therapy, it was decided to attempt treatment on an ego level emphasizing catharsis, reassurance and re-education, carefully observing his behavior for any indications of psychosis.

Treatment was largely in the form of catharsis. Jack was eventually able to verbalize his fears when he said, "I know I'm going crazy; I just can't control myself anymore. If I don't go home I worry and when I go home I have no peace and get worse. There's nothing to live for". After outbursts similar to this Jack would frequently burst into tears with his body shaken by sobs. He would state his feeling of relief in being able to talk to someone.

Since Jack spent all of his time in the barracks worrying and almost appearing in "dream world" and talking to himself, an attempt was made to widen his activities by inviting him to join the worker in a movie. The patient was tense and restless throughout and not able to summarize the plot afterwards. The occupational therapist, physical training instructor, and barracks sergeant, whose aid had been enlisted in this case, also found little response.

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Since there seemed to be increased preoccupation and lack of emotional tone in Jack's speech and he seemed to feel that everything was closing in on him and the burden was too much to bear, another conference was held on this case. The psychiatrist revealed that he had received a letter from the clinic which was treating the patient's wife, which offered to treat our patient. On the basis of this, it was decided to discharge Jack into their care.

### The case of Jim

This twenty-eight year old single S/Sgt. enlisted in the Army on 3 September 1937 and spent three years in Panama. After his discharge he worked as a cook for a few months and then reenlisted 25 January 1941. Jim spent practically all his time in service in the area around Ft. Johnston in the medical department doing clerical, x-ray and laboratory work.

Patient claims to have noted a feeling of easy fatigability, shortness of breath and palpitation for the past eighteen months, but made no mention of this. A diagnosis of psychoneurosis, with concomitant remarks and jokes about this by fellow patients and civilians and a mild feeling of persecution aggravated his condition. In August 1944 he was ordered to a new assignment which he considered unfair and he became confused and went AWOL for six hours. Jim was transferred to Lovell General Hospital for mental examination prior to court-martial. There it was felt that "mild neurotic traits which had appeared in the last eighteen months had made the patient less efficient and secure in his position". On their recommendation court-martial charges were dropped and Jim was transferred to Convalescent Hospital for treatment.

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Jim's father is a chronic alcoholic who has been hospitalized several times for mental illness caused by his excessive use of alcohol. When patient was seven years old, his mother died in childbirth.

He and his sisters became wards of the state after the death of their mother and patient was boarded with a family who beat him for the slightest misdemeanor and made him go to school in rags. Jim is the eldest of three children. He has always been rather a seclusive person and did not seem to get along with people. The only neurotic trait mentioned was talking in his sleep. He graduated from high school at seventeen and subsequently worked at odd jobs interspersed with a year and a half in the CCC's. His social, athletic and sexual adjustment were poor.

Jim presented the picture of an over serious, over conscientious individual with a tendency toward seclusiveness and a great deal of feeling and emphasized the idea that he had been persecuted at his last post.

It was felt that catharsis, reassurance and suggestion would be of value and that in addition perhaps Jim could be given a better understanding of himself.

Some of his anxiety was due to his fear of being returned to his previous organization so a transfer was initiated in accordance with his request. This aided in establishing confidence transference and he was able to express himself. The picture was of a soldier who in spite of two and one-half years in an organization had made no friends and had not developed any hobbies or leisure time activities. He was in charge of men whom he could not handle and were quick to see

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It was felt in view of his personality and the effect of inactivity that he might be effectively utilized as a clerk in our company office. He worked long hours and conscientiously though slowly and with a large quota of errors.

On several occasions in informal interviews, Jim discussed his personal and family history. Although he could see all the events in his life and had read a number of books on psychology, he would admit little insight. He did show some changes such as being less seclusive, relating more easily, using work less as an escape, dressing more neatly, bathing more often and even smoking whole cigarettes. It was felt in view of these factors that there was some insight even though Jim was not willing to share it. He was eventually assigned to our cadre and served a year and a half (including the time as a patient).

It might be added that the worker met Jim after his discharge (on the basis of length of service) and he was studying X-ray and medical laboratory work and doing well. He was also apparently making a fair adjustment to his environment and had a good understanding of himself.

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Discussion: Two Men Who Broke Down in the United States

Jack and Jim differed in several ways. Jack was a very dependent individual with strong feelings of inferiority and inadequacy while Jim was more of a rigid person who tended to be more suspicious of the attentions and intentions of others.

Jack had a more pronounced civilian history and a precarious home situation. Jack was small and puny with a sickly pallor, while Jim was fairly tall, well built with good potentialities for physical development. Jack should have been rejected at the induction center. Jim is an example of the value of "special posting".

They had many things in common including a poor childhood environment and family history, poor social and athletic adjustment, and poor work histories.

To sum up some of the factors in treatment we can make the following points:

1. In the case of Jack, treatment was in the form of catharsis, observation and an attempt at socialization. The final disposition was based on the plan of treatment by a civilian psychiatrist because his type of case did not come under the function of a Convalescent Hospital.
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2. In Jim's case treatment was largely in the form of catharsis and manipulation. The use of manipulation of the environment

(Jim's assignment as clerk and transfer from previous organization) illustrates a constructive use of function for he was eventually salvaged for duty. Although he was wary about admitting it, Jim did have fair insight into his personality. He is apparently making an adequate civilian adjustment.

3. There was a utilization of the psychiatrist, psychiatric social work supervisor, physical training instructor, barracks sergeant, and occupational therapist as part of the total treatment plan.

#### 4. Two Cases of Mental Deficiency

These are two examples of difficulties of individuals with limited intelligence in adjusting to the army situation which in effect was a new culture. To properly evaluate the inter-relationship between the mental deficiency and psychoneurotic symptoms in terms of cause and effect frequently was extremely difficult as in the case of George. It is much clearer in James's situation.

##### The Case of George

This patient was seen in two scheduled interviews plus a few informal contacts.

George was inducted in May 1944. He was resolved "to be a good soldier, was never late for formation and was only on sick call once". He went overseas in November, '44 and saw ten days of combat during January and February 1945. He was afraid and tremulous from the first but went out on patrols determined that he "could take it". At times it seemed that his legs wouldn't move. On 3 February 1945 when he was lying



in a hole with another soldier pinned down by the Germans, he had a marked fear reaction and became panicky and ran back to the Command Post reporting to the Lieutenant that he should be court-martialed because he left his post. George was hospitalized at this time because of this "panic reaction, tics, and agitated movements, anxiety, and ideas of self-condemnation". There was an additional diagnosis of "mental deficiency, moron, mental age nine years (Kent Emergency Test)". Patient's anxiety and feelings of guilt and worthlessness became so marked that he was transferred to a closed ward where a sheet pack became necessary. He was returned to the Zone of Interior and after a few months in a general hospital was transferred to Convalescent Hospital for treatment and disposition.

George was the eldest of twelve children. His father was a laborer who was prone to alcoholic sprees so that the family suffered from poor emotional as well as economic conditions. His father and mother often quarreled and the former would occasionally beat his wife and children.

Patient was an enuretic until the age of twelve, was afraid of the dark and had somnervous tics. He went as far as the sixth grade; had a poor school record; started to work at an early age. His employment history shows N.Y.A., W.P.A., and then finally a job in a box factory for the four years prior to his induction. Although he was treated for ulcers in 1943, he was apparently in good health when inducted in 1944. He married at the age of twenty-one and has a son three and one-half years old. Patient seemed to be very dependent on his wife.

At Camp Edwards Convalescent Hospital, medical examinations and laboratory tests were negative and a Bellevue-Wechsler confirmed the diagnosis of mental deficiency.



George presented the picture of an extremely conscientious mental deficient with a poor family and personal emotional history plus a strong feeling of social inferiority. His desire for social acceptance produced a strong guilt reaction to his inability to handle his fears under combat stress. When first seen he was extremely tense and anxious with marked anxiety symptoms of which stuttering, blinking of the eyes, irritability and a "startle reaction" were most prominent. He had ambivalent feelings about his disposition as manifested by his fear of return to duty on the one hand and strong guilt feelings on the other. It was felt that abreaction and reassurance would be important in this case and though little could be expected in the way of insight, some suggestion and persuasion might be of value.

Although abreaction was of value in this situation, it developed that reassurance that he would not "go crazy" was needed most. George related everything to this saying at one time, "I'm sure I'm going crazy; I couldn't even satisfy my wife". Reassurance bolstered by suggestion and persuasion was given by stressing George's identity with the other men in the barracks and by simple and crude analogy the relation between the emotions and our physical well-being. The fact that he was not in a closed ward and that we planned to send him home soon was stressed as part of our confidence in his ability to get well soon.



Patient seemed to have been able to derive enough from the contact to aid him in his present difficulty and by the end of the contacts was less tense and anxious and his sexual adjustment had improved.

### The case of James

The case was handled in three scheduled interviews plus a few informal contacts. This type of situation has frequently been diagnosed overseas as psychosis.

James was a twenty-five year old, white, single private with three years of service of which eighteen months were overseas. Although he was assigned to the infantry, he never qualified with a rifle. Overseas he served six months with the Rangers. He had only one day of combat but occasionally helped haul rations to the front lines and on a few occasions was subject to air raids. He was transferred to Headquarters as they felt he "could not stand the gaff". When James was hospitalized for malaria in September 1943, he showed symptoms of psycho-neuroses and was reclassified accordingly. During the period from May 3, 1944 to December 9, 1944 he was hospitalized for either psychoneurosis or malaria or both. It was finally decided in December 1944 that evacuation to the United States was necessary.

Patient's father, aged 65, works irregularly as a "woods boss"; he is a "nervous person". Patient's mother died in 1938 from a "stomach ulcer". He is the fourth of four children. He was raised in a town of five hundred population in Maine. James has been shy and self-conscious all his life; but does seem to have made a fair athletic adjustment and some attempt at socializing. He is closely attached to his father. Patient left the seventh grade at sixteen after spending four years in the fourth grade. He "studied hard but just couldn't learn. James held various jobs

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as a lumberjack and in a box factory, the longest of which was three months. He would "get fed up and want a change". He liked his last job, however, and plans to return there upon his separation. He has a tendency to "get drunk once a week" and stated that he began this prior to induction. James stated that he had frequent sexual intercourse while in the army and in civilian life.

The overseas records spoke of him "hearing voices" and suggested the possibility of psychosis. His complaints during the first interview were an abiding sense of weakness, and incapacity, inability to concentrate, talking in his sleep, and worry about his dad and girl, "even tho I know they are O.K." In talking to James it appeared that he had borderline intelligence and seemed rather confused by his whole army experience. He was rather vague in terms of dates and events related to this. Psychological tests and a psychiatric examination while confirming the diagnosis of mental deficiency found no evidence of psychoses.

It was felt that, although the best therapy would be to return him to his home, some help could be given in the form of abreaction, reassurance and suggestion.

The process of catharsis was quite helpful because here for probably the first time in his army career James was able to express his feelings of homesickness and how everything seemed to have happened so fast that he never knew what was going on. "I tried my best to be a good soldier, but I couldn't learn good. The more they yelled, the worse I got." He was able to relate some of his fears to a civilian experience in



which he injured his brother while hunting deer. James seemed quite relieved to get this out of his system and calmed down considerably after expressing this feeling and being given some measure of reassurance by the worker.

James came very much under the influence of another patient - an alcoholic psychopath - and as a consequence began to drink more heavily and apparently got into a few fights while inebriated. Because of the difficulty of controlling this type of a relationship in the army setting, early disposition was decided upon.

In the final interview the subject of drinking was discussed in terms of why men drink and the dangers of the use of alcohol as an escape. His future plans were discussed with some confidence on the part of James, since his old job had been promised him and he was planning to marry his girl friend.

It was felt that James had gained something from treatment and would at least make an adjustment on his pre-induction level.

#### Discussion of Two Cases of Mental Deficiency

These cases were different in the sense that George had a more definite psychiatric history, family and personal history plus an overconscientiousness and a lack of appreciation of his own limitations. James tended to use alcohol for emotional release and was much more easily led. It is probably true in the latter case that the problems arose more



from James mental deficiency than his neuroticisms.

These cases had the following things in common:

1. The use of psychiatric consultation and psychological testing to clarify the diagnosis was particularly important in the case of James when the overseas record indicated psychosis.
2. Acceptance as a soldier and a man was especially important in this type of situation; but at the same time the worker had to avoid excessive dependency on the part of the patient.
3. Treatment was on the basis of catharsis, suggestion, and a little persuasion, plus reassurance and reorientation. George gained superficial insight.
4. The effect of the new culture - the army was important in both cases, but particularly significant in the case of James who made a fair adjustment on a more primitive level. In both of these situations there is the question of the effect "special posting" 18/ would have had for more profitable utilization of these men.

##### 5. "Constitutional Psychopathic State"

Although these men are called "psychopaths", the term is meant in a more limited sense to designate those who could not or would not conform to authority. Because of their attitudes and behavior, their presence in any army outfit might be considered more of a negative value.

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### The case of Dominick

Although this patient was seen in only two scheduled interviews, his behavior was closely observed.

Dominick was a twenty-two year old single white Corporal. He was the fifth of five children. One brother was discharged from the U.S. Army for "ulcers". His mother, to whom he was closely attached, died in 1940. His father, a street cleaner, cannot speak English and is a heavy drinker. Patient had the normal childhood diseases.

Dominick was more interested in sports than an education in high school and failed several courses. He left after his father told him to stop playing ball and get a job. His work history is poor, including jobs at a bingo game, laundry and shipyards, as well as several months in the CCC. Although he had little orientation on the basis of the present struggle, he enlisted in 1940 and served with a cannon company attached to the 42nd Division. His complaints of stomach trouble and headaches increased in proportion to the danger. He was hospitalized six times for malaria and was evacuated for this and psychoneurosis. He had several court-martials and a strong conflict with those in authority.

A Minnesota Multiphasic Personality Inventory showed psychopathic tendencies and the psychiatrist felt that there was a large factor of malingering and that Dominick could do duty.

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a desire for status. He lacked the sense of belonging. Patient enlisted shortly after the death of his mother, who apparently represented his drive for status. This enlistment wasn't through any sense of patriotism, but partly as an attempt to secure status and partly as an escape. His army history, which showed after an initial period of adjustment, court-martials for minor offenses and some conflict with authority was a continuation of frustration in his drive for status.

It was felt that in line with the psychiatrist's recommendations that treatment would be attempted in terms of possible return to duty.

In spite of all efforts by the worker, it was impossible even to establish rapport. When an attempt at bribery and "some of my best friends are ...." approach failed, he merely continued to insist that he was sick and that he would be cured when he was sent home. Although he carefully adhered to all phases of the program, cooperation was in form rather than substance. Various attempts to appeal to him on both a patriotic and intellectual level were made without avail. The point was finally reached, after two interviews, when it was felt that it was not justified to spend more time on this patient because others needed and could utilize this help to better advantage.

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In spite of all efforts by the worker, it was impossible

even to establish rapport. When an attempt at bribery and "some of my best friends are ...." approach failed, he merely

continued to insist that he was sick and that he would be cured when he was sent home. Although he carefully adhered to all phases of the program, cooperation was in form rather than substance. Various attempts to appeal to him on both a patriotic and intellectual level were made without avail. The point was finally reached, after two interviews, when it was felt that it was not justified to spend more time on this patient because others needed and could utilize this help to better advantage.

### The case of Paul

There was one scheduled interview and the patient was observed in the various activities.

Paul was a twenty-five year old white private. He had four years and seven months overseas. He saw combat in Africa and Italy before he was hospitalized in February 1945 and evacuated to the Zone of Operations because of reactive repression. He had previously been court-martialed overseas for drunkenness, abusing an officer, molesting civilians, destruction of government property, and excessive drinking. In February 1942 he was fined two-thirds of his pay and sentenced to six months at hard labor. Paul had about five or six other court-martials, including a similar six months sentence before going overseas. He was examined in 1944 for discharge as a psychopathic personality under AR 615-368. The decision of the medical department, however, was reversed and he was sent back to duty. It was felt overseas that he was "a severe alcoholic psychopath but the picture was one at present of a severe depression with paranoid trends".

Paul's parents are living and well. He has three siblings also living and well.

The patient's past history revealed that his birth and early physical development were apparently normal. He completed the ninth grade at the age of sixteen, having failed the third grade. He was frequently truant. Patient worked as a laborer from the age of sixteen to twenty-one at which time he enlisted in the army. These jobs were of varied duration with frequent "rest periods" between them. He was arrested once for stealing coal. He married at the age of twenty-one and there is one child, living and well. He states that his marriage is compatible.

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In talking to Paul, it appeared that his depression had lifted and there were no paranoid ideas apparent. This probably was largely due to the fact that the situational stress of the danger of foreign duty and combat was removed and Paul was in an army hospital with little rigid discipline.

The problem, at least on the surface, was of difficulty in conforming to authority. The civilian history, for which in this case we were solely dependent on the patient, was very sketchy. It was apparent that his school and work history, two fairly reliable indicators of the prognosis for army adjustment, were poor with at least one admitted arrest. There was some tendency toward alcoholism in civilian life and his marital adjustment was questionable in spite of his statements to the contrary. His army history was exceedingly poor and with serious and frequent breaches of discipline, which made him of dubious value.

The patient's attitude was one of belligerency with almost an open flaunting of authority and he disrupted morale by his loud and continuous gripes. Disciplinary measures for various minor infractions proved of little avail.

This was a borderline situation between psychiatric and administrative function. Treatment would have been of little value and technically Paul should have been sent back to duty and disposed of through administrative channels.



Because of the difficulties involved, however, he was given a Certificate of Disability Discharge.

### Discussion of Two Cases of Constitutional Psychopathic State.

Though having many things in common, these cases differed in several ways. In Dominick's case we had a definite family history with the death of his mother, an illiterate and alcoholic father, a stepmother with whom he had little in common, a clash between first and second generations, a strong sense of social inferiority compensated for by a drive for status. Paul apparently had a normal family adjustment and no marked neuroticisms; but had a tendency toward alcoholism and one arrest for stealing. While Dominick's pattern was a borderline one, Paul was clearly an administrative problem from the army standpoint.

These cases had the following things in common:

1. A poor school and work record and a continuous conflict with authority in the army.
2. The question as to whether these were medical or administrative problems as well as the poor prognosis for future service and the questionable value of treatment.
3. The potential as well as actual threat to group morale.
4. The need for a social history supplied by civilian sources.

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## 6. Two cases of Conversion Hysteria

In many cases there are long periods of anxiety which the patient attempted to control, because apparently his ego is unable to admit his inability to handle the situation. Often the anxiety is replaced by physical symptoms which prove disabling and that the patient can more readily accept. This seems to be the situation in these two cases.

### The case of Anthony

The case was handled in four scheduled interviews:

Anthony is a thirty-four year old, married Staff Sergeant who was drafted in July 1942. He was overseas eight months. Patient was a squad leader in an infantry platoon and had five months of combat in the European theatre. He was hospitalized in April 1945 because of "myalgia". He had pains in his hips, legs and shoulders and extreme difficulty in walking. Patient has had similar pains since 1938; but in March 1945 they began to be disabling. In February 1945 he was accidentally shot in the left ankle by a U.S. soldier and received medical care.

Patient's mother has "high blood pressure". His father and seven siblings are "high strung".

Anthony had the usual childhood diseases. Patient talked in his sleep, had nightmares, bit his nails, had temper tantrums, and wet his bed occasionally until the age of twelve. He apparently made a normal athletic, social and sexual adjustment. He left High school during the first year "to go to work". Patient has been a "free lance commercial artist" for the last fifteen years.

In 1938 he volunteered to serve with the Loyalist forces in Spain and spent one year



and eight months there in the infantry and as an ambulance driver. His present symptoms appear to have had their inception at this time.

The social worker felt that he was confronted with a dilemma. Here was a patient with a conversion hysteria. He had a long history of neuroticism to which he had adjusted fairly well largely through a fortunate choice of an occupation and previous absence of traumatic experiences.

His family had a long history of liberal traditions and its male members as well as patient's fiancée had achieved status in this area by virtue of their responsible positions in the labor movement. Patient had strong inferiority feelings because of his lack of education, the nature of his job and his lack of prestige. His participation in the Spanish Civil War was his bid for status. He carried on despite a conversion hysteria that almost proved disabling. Additional combat service in the United States Army proved too much and he developed the present symptoms. Since they served the valuable purpose of preserving the patient's ego, the psychiatric social worker was confronted with the question of the goal in treatment. It was decided that since long term therapy (such as a complete or partial analysis) was not possible in this situation, a "direct attack" on these symptoms would be devastating to Anthony's ego. Therefore "ego support" was decided upon, plus some abreaction.

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The patient was quite restrained at first probably because he was feeling-out the relationship plus the need to be on the defensive because of frequent recrimination due to his fighting in Spain. But gradually a confidence transference was established on the basis of the worker's identification with some of Anthony's thinking on the subject. He was then able to give vent with a great deal of emotion and some bitterness about the treatment he had received because he "recognized our enemy early".

The worker attempted to bolster Anthony's ego by commenting on his wide interest and knowledge on a variety of subjects (brought out in the interview) as well as a high Bellevue-Wechsler (IQ 129) and his good marks on all High School Achievement Tests except mathematics. He responded to this by exclaiming, "Now I see what you are getting at. You are trying to show me that I sell myself short, aren't you?" This was used as a basis to discuss his feelings of inferiority and then some of his strong points which were a good appearance, pleasing personality, an ability to get along with people and a high social quotient. Suggestion and persuasion was used to get these ideas across.

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### The case of Hal

Hal was a thirty-eight year old married Technician fifth grade with two years of service of which eight months was overseas. Patient had four months combat as a litter bearer and and company aid man attached to infantry in European Theatre of Operation. Hal injured his back in March 1945 when he tripped when carrying a litter. In April 1945, the pain not having lessened, he sought medical aid and was hospitalized on 21 April 1945. Before Hal went overseas, he spent three weeks in the hospital for nasal pharyngitis. He was treated for a sciatica in the right leg and spine.

Hal's father died thirteen years ago and his mother eight years ago from "heart disease". One brother died when he was young from pneumonia. Another brother died after the last war in a fall from a telephone pole.

He had pneumonia three times as a child. He participated in sports very little, and left school in the second half of the seventh grade to go to work. He had been working largely in hotels in charge of service and as a bartender.

Hal has been married for eight years; he has no children. His wife had an operation for removal of an ovary and is at present under doctor's care for this and "nerves".

Although Hal complained only of his back, it appeared in talking to him that he was controlling a great deal of emotion and was also anxious about his wife. He was felt that even though it might not be possible to cure his conversion symptoms that therapy could be some help in terms of abreaction and some catharsis.

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ing to him that because of his age he could not be returned to duty under existing regulations. He gradually was able to give vent to his feelings about the physical and emotional strain that had steadily mounted during service and his four months of combat. He hadn't expected to be drafted and certainly not to be sent overseas or into combat. Hal expressed the struggle in the matter of fact tone that betrayed little emotion by such phrases as "I tried to grit my teeth and keep going" and "It was tough for the kids but worse for me". The worker was able to establish some intellectual acceptance of the relationship between emotional and physical symptoms which had been aided by some ideas Hal had gained from the Group Therapy sessions. He could not, however, relate it to his back condition which he considered a purely physical thing. Perhaps his ego needed these symptoms but certainly his hospitalization for over six months mainly as a physical patient, treatment with ultra-violet ray, plus a doctor's careless (misinterpreted) remark that the patient would be lucky if he could walk straight proved too much a barrier to short term therapy.

#### Discussion of two cases of conversion Hysteria

The cases differed in the sense that Anthony was younger and had an average athletic, sexual and job adjustment and had a greater motivation. Hal's parents and two brothers had died through illness or accidents; had had been a sickly child with a poor athletic and social adjustment. At the same time both men had a contributing civilian history, were doubtful combat material, had at least four months of traumatic exper-

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ience and had similar symptoms. The following were of significance in this treatment:

1. The value of the other phases of the program were shown in Hal's relating the lectures to himself and the use of the Wechsler and High School Achievement Tests for Anthony.
2. In Hal's case it was possible to relieve some of the stress early in the contact by telling him that he would be discharged. It was also possible to remove some of the anxiety by doing some general interpretation of the nature of his wife's operation.
3. Treatment was largely on the basis of catharsis, desensitization (more in Hal's case) giving the patient some insight (also more in Hal's case) and ego support (more in Anthony's case).

#### 7. Example of the Use of the Psychiatric Social Worker to Aid in Diagnosis

##### The case of John

John was a thirty-two year old, white, single Private First Class with two years and nine months service, of which ten months were overseas. He had three months of combat as a rifleman and spent eighty-seven days as a German prisoner. After his release by American troops he was hospitalized for "malnutrition, pneumonia and severe anxiety symptoms". Patient had numerous headaches and colds during basic training and was a frequent visitor on sick call for these symptoms. Patient had been court-martialed four times; three were for AWOL and one for sleeping on guard duty.

John was the youngest of four children. He denies any psychiatric determinants in them or in his parents. Patient had the usual childhood diseases. He speaks vaguely of "spasms" as a child, but no

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definite information was elicited about this. Patient seems to have been very close to his mother. John would stay around the house rather than mix with the other children in the neighborhood. He did not participate in sports and had no dates or desire for feminine company.

John finished a commercial course in high school at the age of seventeen. Patient then worked irregularly as a junior clerk and in a factory. Patient enlisted in the Coast Guard in November, 1941, and served until October, 1942. He was given a discharge for "inaptitude because he did not want to take a special course".

In talking to John the impression was of dulling of affect, preoccupation and a tendency toward depression. He complained of "being in a fog" and headaches.

The worker thought that the patient, in view of his behavior in the interview and his history, possibly had psychotic trends. A Rorschach test showed "some tendency toward disability because of his neuroticisms but no evidence of psychoses" and a Bellevue-Wechsler "some evidence of deterioration". The psychiatrist felt there was some evidence of primordial schizophrenia. It was decided in this case temporarily to limit the work of the social worker to observation of John in the barracks and informal interviews wherever and whenever practical and necessary.

In observation of the patient in the barracks on a few occasions, it was noted that John was detached from the

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rest of the men and seemingly unaware of or not interested in their presence. He slept whenever the occasion presented itself - day or night. The Rorschach and a Bellevue Wechsler seemed to have disturbed him and he felt that "there was some trick to prove him crazy".

The worker suspected that John had been drinking heavily, but saw no evidence that he brought any intoxicants into the barracks. He did notice, however, that the patient did imbibe PX beer, which apparently had a rapid and intoxicating effect on him. It was noted that particularly after John returned from a weekend pass he was usually heavily intoxicated and more depressed". On one of these occasions the worker helped John, who had apparently been stumbling around in a daze for some time, find his barracks. When he arrived he opened his footlocker and asked, "Have a drink, Sarge?". This was diplomatically refused; but used as the basis for a profitable interview.

It developed that John began to drink in a brokerage office because "A nip now and then steadied my nerves". He told how he always felt alone even in the company of people "Because they picked on me and talked about me" and then gradually began to drink by himself. He had been arrested a few times for drunkenness and vagrancy. He became somewhat disturbed when the worker started to question him superficially about his sexual adjustment and the "interview" was terminated

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When the case was discussed again in conference it was decided that in view of the patient's background, chronic alcoholism, seclusiveness, preoccupation, poor sexual adjustment and letters from home complaining of John's poor adjustment, to transfer John to the General Hospital for further observation and treatment.

#### Discussion of the Use of the Psychiatric Social Worker as Aiding in Diagnosis

Here we see the worker in a role that we do not usually consider as typically his. There were cases such as this when the psychiatrist, due to his own lacks or to the nature of his duties, was in need of added information to aid in determination as to whether the nature of the patient's illness fell within the scope of the function of our facility.

The structure was such that all the material could be obtained, except for the necessary interview for a social history by virtue of the fact that the social worker was in a unique position to supplement the knowledge and information about the patient as well as be available in the event of difficulty.

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## CHAPTER IV

### SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

In this thesis, the writer has attempted to present a description of the Neuropsychiatric Section of Camp Edwards Convalescent Hospital with special emphasis on psychiatric social work. An overall picture was presented in terms of a brief history, discussion of the structure, differentiation from a civilian mental hospital, types of cases and types of treatment. The role of the psychiatric social worker in individual and group therapy was presented first in general terms and then in the light of the experience of the writer on the basis of his case load to better understand the problems, techniques and goals of treatment.

It would be advisable since there are some differences in function and structure from a civilian hospital, to consider these first. These limitations and problems that are not always faced by the civilian hospital included the fact that there was little opportunity for the hospital to determine its own policies and selection of personnel (the latter was generally poorly trained), there was no incentive for good work by the staff, the records were frequently poor and inadequate, securing outside material for social histories was extremely difficult. In addition the patients were "unselected", and been hospitalized for periods of at least six months with



little treatment, the value of the medical clearance was questionable, army environment itself was an irritating factor, and there was the element of secondary gain. This last factor was bolstered by the civilian attitude of either coddling the patient and telling him his job was done and/or reflecting fear and uneasiness because of lack of ability to understand the patient's difficulty.

At the same time there were some advantages over a civilian hospital. One of these was the fact that there was no monetary problem (though it was easier to have a gym built than secure a box of paper clips). It was possible to secure almost unlimited facilities for occupational therapy, physical training and recreation. The worker was in a unique position to observe the patient in practically every phase of his existence and he even lived in the same barracks and ate in the same mess hall as his patients.

What then can be said about the background of the patients? Most of the patients in the study had a history of a personal and/or family neuroticisms and usually a tendency toward lack of social athletic, school, and/or work adjustments. The motives behind the patient's "enlistment" were usually revealing. In many such cases it would seem that the man was a poor risk and if inducted certainly should have been considered as questionable combat material. Here the value of "special posting" would seem apparent.

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The reason for the presense of those patients at Camp Edwards Convalescent Hospital was for treatment. The term "treatment", while generally used in a specific application to individual and group psychotherapy, could in a sense be applied to the entire daily schedule. The physical training, occupational therapy, classes for various interests plus the recreational activities served a valuable purpose in keeping the patient from centering his attention on himself and his symptoms and also served as a useful channelizing of hostility and aggression. Many of the workers in these activities as well as many of the barracks sergeants cooperated closely in aiding the total treatment plan either actively or with many helpful observations. Psychological testing and counseling also played a part in the total effort to help get the patient well.

The role of the psychiatric social worker was considered as relating more specifically to group and individual therapy. The use of group therapy was a necessity because it was the sole basis of treatment for from eighty to eightyfive percent of the patients. It served the following valuable purposes:

1. The sessions were so controlled that the patient received a reeducation by means of the wider group experience of which the sessions were a part.
2. They served as catharsis and helped satisfy the neurotic need for attention.



3. The need for meeting problems as they occur and maintaining good morale.
4. The function of reducing secondary anxiety and guilt feelings.
5. They aided the patients to see their own problems through identification with those of others.
6. They helped bring about the acceptance of the sharing nature of treatment.
7. By this method individual resistance was lessened and therefore the patient could bring forth additional information about himself.
8. Individual problems would come to light that could be followed up in individual treatment.
9. It was a valuable adjunct to individual therapy.

Although because of necessity group therapy was the only psychotherapy for about 80% of the patients, in the rest of the cases individual treatment was attempted. With a constructive use of function and an appreciation of and acceptance of limitations as practiced in this situation, it was felt that short contact interviewing of a high professional standard was accomplished. (The writer had the advantage of good psychiatric and psychiatric case work supervision plus a second year of graduate work). This was especially necessary

3. The need for meeting problems as they occur and maintaining good morale.
4. The function of reducing secondary anxiety and guilt feelings.
5. They aided the patients to see their own problems through identification with those of others.
6. They helped bring about the acceptance of the sharing nature of treatment.
7. By this method individual resistance was lessened and therefore the patient could bring forth additional information about himself.
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in order to keep one's perspective with a large case load and inexperienced personnel.

The acceptance of limitations also necessitated that, since the number of interviews averaged about five, the treatment goal be adjusted accordingly. Thus, although a long standing pattern of neuroticisms as well as the need for help in many areas might be obvious, therapy had to be concentrated on the present problem and symptoms. This meant that the case work relationship was on an ego level and the tools used were abreaction (or catharsis) desensitization, reassurance, suggestion, discussion of life history, bibliotherapy, ego support, manipulation and a little persuasion.

The fact that the worker was a fellow G.I. gave the patient a feeling of friendly non-judgmental acceptance and understanding. The assurance that here was someone sincerely interested in him and his problems enabled the patient to relax and made the establishment of rapport in most cases (excluding psychopaths) relatively easy. A frank and honest approach with the exercising of care not to over identify with his unjustified gripes usually completed the picture. Since this was a reality situation in which the worker felt secure in his role, it was not necessary to disguise the fact that he was a fellow soldier, by such means as wearing a white coat which were discussed by Sgt. Feldberg.<sup>18/</sup> The most important

<sup>18/</sup> Theodore M. Feldberg, and Seymour J. Rosenberg - The Psychiatric Social Worker in an Army Station Hospital, pp461-68

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thing was for the worker to understand the meaning of the symptoms to the patient.

The rapport established the basis for catharsis which was fundamental as a step in any treatment plan for its value in itself as well as to make other techniques possible. Once the worker had established himself in his role as a helping person, the patient was able to release some of his anxieties, fears and conflicts. This was true because this experience was unique in his army experience and "civilians couldn't understand" what he had been through. The value of this was very marked in the decrease of subjective complaints as well as objective symptoms. When there was time available, it was felt valuable to have the patient relate the traumatic experience two or more times so that most of the anxiety associated with it would diminish and it would assume more normal proportions in his life history.

Usually the feeling of guilt associated with the neurosis or secondary anxiety over the symptoms could be relieved by the worker's reassurance which would be expressed either by words or "feeling tone". The fact that he could talk to someone who could identify with him and who did not represent authority was frequently reassurance in itself.

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use is illustrated in practically all of the examples presented in this study.

The discussion of the patient's life history often aided in giving the patient a better understanding of himself and as a result he was in some cases better from a psychiatric standpoint than at the time of his induction. In connection with this bibliotherapy was utilized in general (a library had been established in the writer's barracks) and patients were asked to read certain material in specific cases. In the latter situation this material was discussed in individual interviews.

Although the material in the previous paragraph can very aptly be called techniques of ego support, the discussion of the individual's strengths was often a means of raising the individual's confidence and self esteem and thereby lessening his need for symptoms.

Another technique used in treatment and perhaps most generally considered a social work tool was "manipulation". It could perhaps be called the cornerstone of the whole program. The daily schedule and the leisure time activities were valuable environmental manipulation for men who had been lying in hospital wards for six or more months with little to do except worry and gripe. The use of the occupational therapists, teachers, physical instructors, barracks sergeants, and even

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other patients aided in manipulation of the individual as part of the treatment plan. Assignment of various men to different jobs in the hospital was also in the same area.

Although persuasion and reeducation were used in limited degree, they were valuable in a few cases in conjunction with the other tools to achieve the desired goal-insight into the nature of the symptoms. They had limited value as case work tools, however, and had to be used very carefully as the "appeal to reason" was often disappointing in its results.

These techniques in conjunction with the scheduled interviews and day to day program only told part of the picture. The ability to talk to the men informally at mess, in the barracks, in the latrine, in the camp area and outside, either individually or in groups served as a valuable adjunct to the entire treatment process. It was here that the worker "proved he was one of the boys". These settings were the key to the whole program because of the free give and take as well as the revealing of material that might never come to the surface.

A combination of these techniques was valuable in all cases (except the "psychopath") and showed varied results from relief of some of the anxiety to almost complete insight. In one instance on which a follow-up was available, we can say that the patient was apparently making a better adjustment than before his induction. In terms of the "psychopath"

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the difficulty in getting a "reliable" social history and the factors of malingering and difficulty in treatment, and the vacuum in jurisdiction between the medical and the administrative branches, there seemed to be little value in admitting psychopaths to the Camp Edwards Convalescent Hospital. In fact, it might be said that their presence was detrimental because of their effect on morale.

The above material demonstrates the valuable knowledge and experience that the psychiatric social worker gained in his own field. This extended to psychiatry and psychology as well. Because of the danger (due to the rapid turnover) of neglecting to discover cases of psychoses, epilepsy, or possible organic diseases and in view of the need to evaluate his treatment role, the psychiatric social worker found a knowledge of psychiatric diagnoses and symptoms was necessary. He has found it necessary to administer and evaluate intelligence, aptitude and personality tests as well as to participate in vocational counseling.

Throughout this paper the writer has made many criticisms of the Neuropsychiatric Treatment program. Although it was undoubtedly true that due to the extremely rapid growth of our army and the tremendous pressure to put a fighting force on the field, much of this was "unavoidable", there are a few outstanding needs which are evident as a result of this experience.



1. Democracy must do a better job of indoctrination of its citizens.
2. A better system of screening at the induction Centers utilizing to a greater extent the social worker and the social service index to give the psychiatrist a better basis for his interviews.
3. The following personnel practices are needed:
  - a. Better utilization throughout the army of people trained in psychiatric or related work in areas calling for use of their skills.
  - b. An improved system of in-service training.
  - c. More motivation for the professional staff by means of reward for merit.
  - d. Utilization of qualified civilian personnel both on a consultation and staff basis.
4. A more efficient screening of patients who are to receive treatment in a Convalescent Hospital with emphasis on the elimination of psychopaths.
5. A clearer separation of medical and administrative responsibility in relation to the psychopath.
6. Prompt institution of a planned program of activity and treatment for patients at the point of hospitalization.
7. A means of getting a social history from civilian agencies that will emphasize speed and quality.
8. Group therapy should be conducted with more homogeneous groups of smaller size at a time during the day when the patient would be more responsive and in conjunction with

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8. Group therapy should be conducted with more homogeneous groups of smaller size at a time during the day when the patient would be more responsive and in conjunction with

individual therapy.

9. A system of special posting should be instituted throughout the army for better utilization of personnel.

Approved,

*Richard H. Grant*

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Dean

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